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JANUARY 1987 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY VOL. 86, NO. 1

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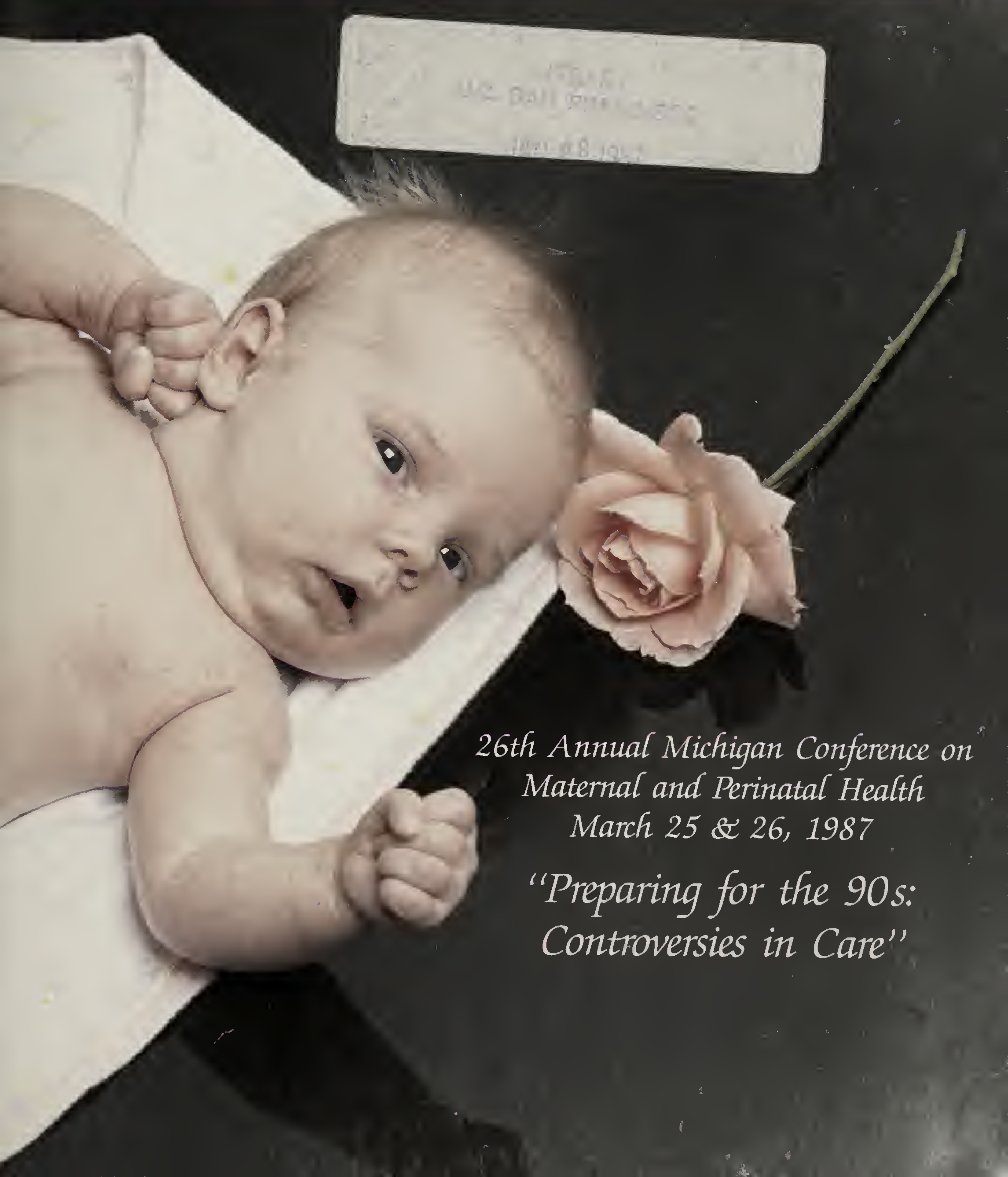


26th Annual Michigan Conference on Maternal and Perinatal Health March 25 & 26, 1987

"Preparing for the 90s: Controversies in Care"

26th Annual Michigan Conference on
Maternal and Perinatal Health

March 25 & 26, 1987
Hyatt Regency Dearborn

"Preparing for the 90s:
Controversies in Care"

For details: Sherry Fent, Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823
(517) 337-1351

MICHIGAN
MEDICINE

JANUARY 1987, VOL. 86, NO. 1

Special Report

1987 Michigan Conference on Maternal and Perinatal Health; "Preparing for the 90s: Controversies in Care" is the theme of this year's March 25-26 conference. A complete preliminary program and registration form are inside. 3

Features

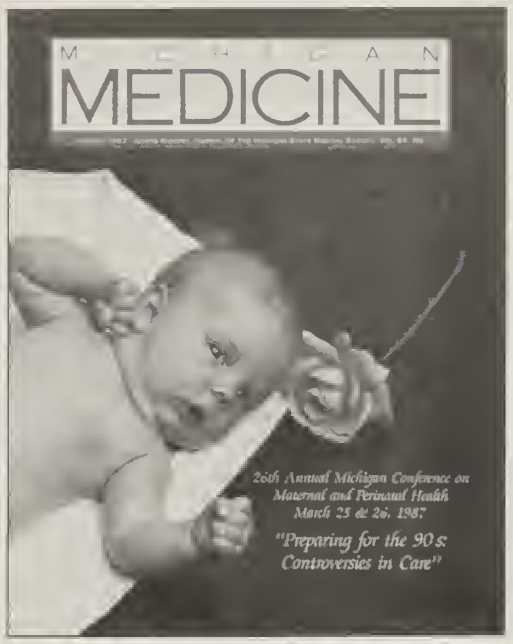
Physician discipline: the process explained
A step-by-step guide from complaint to resolution — By Thomas J. DeKornfeld, MD 14

Litigation is a crippling disease
An address outlining the number one problem facing physicians — By Carl A. Gagliardi, MD 19

Doctors, hospitals, and the new health care: A joint adventure
A look at the forces shaping the new face of patient care — By Spencer C. Johnson 26

Patients needed for these studies
Female patients are sought for studies of amenorrhea and breast cancer 32

Michigan Medicine has a new look! We've combined new ideas with some tried-and-true ones to make your journal more inviting and more readable. Our new "flag" on the cover is set in Copperplate, a classic typeface originally designed for the professions. Inside, the typeface is California, and columns are justified and boxed for easier access. Headlines are centered — a return to traditional style — while photos are bigger and bolder — a contemporary look. We hope you like our new look, and welcome your comments.
SWG



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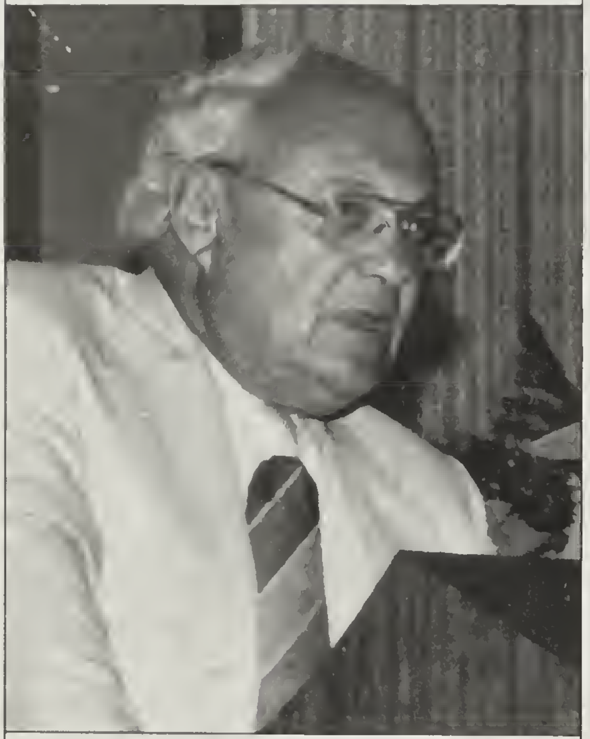
In next month's issue of *Michigan Medicine:* Tax reform — what will it mean for physicians?

About the cover: This year's Conference on Maternal and Perinatal health focuses on postnatal care in particular. Photo by Kim Kauffman

IN MY OPINION

Cost-cutting vs patient welfare



Richard L. Rapport, MD

Doctor Rapport, Flint thoracic surgeon, is a member of the MSMS Board of Directors and Committee on Publications.

Both the number and types of surgery performed on an outpatient basis recently have increased. This change was not initiated by physicians, but resulted from continued attempts by most hospitals, the government, and other third party payors to contain hospital costs and reduce lengths of stay. Although we are not aware of instances in which this change of setting has been detrimental to the health of our patients, some untoward effects are bound to be noted sooner or later. Significant overall reduction in costs has not been demonstrated.

Although this change of setting is acceptable for patients who are in good general health, older patients or those with physical or emotional disturbances make same-day admission or outpatient surgery inadvisable. It is extremely important that the government and other third party payors be made aware that the determination of the advisability for same-day and/or outpatient surgery should be based on the judgement of the individual patient's physician and not on arbitrary, prescribed lists of procedures. As always, the welfare of our patients must be the prime determinant in deciding which procedure should be done in which setting. If current trends continue, society will soon be forced to make a firm decision as to whether or not it should accept the risk of inferior health care for the sole reason of saving dollars. ☐

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. *Michigan Medicine* reserves the right to accept or reject advertising copy. Products and services advertised in *Michigan Medicine* are neither endorsed nor warranted by MSMS.

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26th Annual Michigan Conference on Maternal and Perinatal Health

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March 25 & 26, 1987

Hyatt Regency Dearborn

"Preparing for the 90s: Controversies in Care"

For details: Sherry Fent, Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823
(517) 337-1351

Goals and Objectives for the 26th Annual Michigan Conference on Maternal and Perinatal Health

"Preparing for the 90's: Controversies in Care"

The perinatal health care professional, through attendance at this conference will have an opportunity to interact with a multidisciplinary faculty addressing "controversies in patient care." At the conclusion of the conference, the participant should be able to:

- focus on potential strategies for reducing perinatal mortality.
- discuss the repercussions of some specific drugs adversely affecting perinatal outcome.
- critically review research material for relevancy and credibility.
- understand perinatal brain impairment; specifically the pathological, obstetrical and pediatric components.
- recognize and be prepared for changes in women's health care services in the future.

OBSTETRICAL CONCERNS

- comprehend the growing significance and implication of AIDS in perinatal health.
- describe the etiology and effects of maternal and fetal trauma.
- interpret the fetal physical examination; specifically the biophysical and doppler flow parameters.
- comprehend the current philosophy concerning fetal intervention.
- incorporate risk management philosophies into perinatal medicine.
- detail specific pros and cons for inducing and for waiting in the post-date pregnancy.
- summarize risk factors and possible intervention strategies associated with premature labor.
- bring to light the real significance of maternal serum alpha fetoprotein screening.

PEDIATRIC CONCERNS

- differentiate respiratory distress syndrome from other respiratory problems in the neonatal period.
- familiarize oneself with the newer techniques of monitoring critically ill newborns.
- explain the neonatal jaundice dilemma and other problems associated with early discharge of the newborn.
- discuss the etiology, prevention and sequelae of meconium aspiration syndrome.
- describe resuscitation methods of the newborn and the advantages of extra corporeal membrane oxygenation.
- select those newborns at risk for neonatal apnea and discuss monitoring problems.
- list the factors associated with and the treatment of hyperviscosity syndrome.
- express an awareness of vitamin E supplementation in the newborn—a delicate balance.

Wednesday Morning, March 25

7:30 a.m.
Registration

8:15
General Session: "Preparing for the 90's"
Welcome: **Carl Gagliardi, MD**, Dearborn, President-Elect, Michigan State Medical Society

Moderator: **Steven M. Donn, MD**, Conference Co-Chairman, Associate Professor of Pediatrics, Section of Newborn Services, University of Michigan Medical Center, Ann Arbor

8:30
"Prospects for Reducing Perinatal Mortality"
Stanley M. Garn, PhD, Professor of Nutrition, Department of Community Health Programs, School of Public Health, University of Michigan

9:15
"Low Risk Management of High Risk Labor"
Robert J. Sokol, MD, Professor, Chairman and Chief, Department of Obstetrics and Gynecology, Wayne State University School of Medicine/Hutzel Hospital

External forces, including policies of third party payers and medicolegal liability, have the potential for influencing clinical decision-making in the intrapartum care of the high risk pregnant patient. Should we allow the indication "physician distress" to influence our patient care protocols?

10:00
Break

10:30
"Women's Health Care in the Year 2000"
Karren Kowalski, RN, PhD, Director, Women's Hospital, AMI-St. Luke's, Denver

A historical, current and futuristic assessment of women's health care – "high touch; high tech and high touch/high tech integration."

11:15
"Can You Read"
M. Jeffrey Maisels, MD, Chairman, Department of Pediatrics, William Beaumont Hospital; Clinical Professor of Pediatrics, University of Michigan Medical School

The continuing explosion of medical literature has made it almost impossible to stay current. It becomes essential to be increasingly discriminating in the types of articles we read and accept. This presentation will provide guidelines for critical interpretation of the medical literature.

12 NOON
Adjourn to Luncheon Meetings
(All concurrent sessions):

"Surrogate Pregnancy-Obstetrical Performance and Psychosocial Risks"
Nancy E.K. Reame, RN, PhD, FAAN, Associate Professor of Parent-Child Nursing, School of Nursing, University of Michigan

Women during a surrogate pregnancy may be at increased risk of prenatal anxiety, unprepared childbirth and postpartum emotional dysfunction. Surrogate pregnancy in a clinically screened population may not be complication free. A role for psychosocial stressors in the etiology of these obstetrical problems is proposed.

"Infant Mortality"
George H. Baker, MD, Medical Director for Maternal and Child Health, Bureau of Community Services, Michigan Department of Public Health

Michigan's infant mortality record for 1985 will be reviewed and compared to previous years and to other states. Factors contributing to infant mortality will be discussed and existing programs and new initiatives recommended by the state's Infant Mortality Task Force will be described.

"Advocacy in Maternal and Child Health"
Paul N. Shaheen, Executive Director, Michigan Council for Maternal and Child Health, Lansing

Discussion will revolve around the state's role in maternal and child health priorities, and types of political "currency" which can impact the creation, shape and support of those priorities.

"Premature Rupture of Membranes"
Robert H. Hayashi, MD, Professor and Director, Division of Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, University of Michigan Medical School

Premature rupture of the fetal membranes is a high risk situation. Recent clinical studies have helped to elucidate some of these risks and indicate that management plans need to be altered from what was practiced years ago.

"Perinatal Loss and Bereavement"
Karren Kowalski, RN, PhD, Director, Women's Hospital, AMI-St. Luke's, Denver

The types of loss experienced in today's society and how and why professionals react in various modes to loss and bereavement will be discussed.

Wednesday Afternoon, March 25

Concurrent Sessions in A) Obstetrics and B) Pediatrics

OBSTETRICS: "What's Hot"

Moderator: Robert Hayashi, MD, Professor and Director, Division of Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, University of Michigan

PEDIATRICS: "Respiratory Distress Revisited"

Moderator: William Montgomery, MD, Detroit, President-Elect, American Academy of Pediatrics

1:30

"Perspectives on AIDS in the Future"
John R. Kateley, PhD, Director, Immunology Laboratory, Edward W. Sparrow Hospital, Lansing

Acquired Immune Deficiency Syndrome (AIDS) has emerged as a serious public health emergency with profound ramifications—medical, political, financial and social. AIDS has been called "one of the most serious epidemics confronting man in modern times." The epidemiologic, immunologic and infectious disease complications associated with AIDS in maternal and fetal populations will be discussed.

"Recognition of Respiratory Distress"
Jacqueline R. Francisco, RNC, MS, Supervisor, Neonatal Intensive Care Unit, Bronson Methodist Hospital, Kalamazoo

This presentation will focus on the early recognition of respiratory distress in the neonate. The emphasis will be on clinical assessment skills and the interpretation of additional data to determine a differential diagnosis.

2:00

"Maternal Trauma"
Michael Katz, MD, Assistant Professor, Department of Obstetrics and Gynecology, Children's Hospital and the University of California, San Francisco

"Resuscitation of the Newborn"
William Scott, MD, Staff Neonatologist, Bronson Methodist Hospital, Kalamazoo

This presentation will include discussion of important points regarding resuscitation of the newborn, including airway management, maintenance of effective cardiac activity and blood pressure, drug therapy and meconium aspiration syndrome. Discussion also will include cautions and tips about assessment of neonates, equipment use and vascular access.

2:30

"Fetal Trauma"
Chang Y. Lee, MD, Head, Division of Maternal-Fetal Medicine, Henry Ford Hospital; Clinical Associate Professor, Department of Obstetrics and Gynecology, University of Michigan Medical School

This session will focus on injuries to the fetus and life supporting systems during maternal trauma. Birth trauma in current obstetrics will also be discussed.

"Monitoring the Critically Ill Newborn"
Joanne J. Nicks, RRT, Clinical Specialist in Respiratory Therapy, Department of Pediatric Respiratory Therapy, University of Michigan

This presentation will look at all forms of monitoring which provide a safe, non-invasive approach to cardiopulmonary measurement. Discussion will include application of transcutaneous monitors, end-title CO2, pulse oximeters, mean airway pressure monitoring, and neo-natal pulmonary function studies.

3:00

Break

Break

Wednesday Afternoon, March 25, continued

Obstetrics, continued

Pediatrics, continued

3:15

"Prevention of Premature Labor"
Michael Katz, MD, Assistant Professor, Department of Obstetrics and Gynecology, Children's Hospital and the University of California, San Francisco

Prematurity remains a major obstetrical enigma. Ambulatory identification of premature labor could be a major contribution toward diminishing this problem.

"RDS: A Review and Preview"
Thomas Shaw, MD, Staff Neonatologist, Butterworth Hospital, Grand Rapids

A lecture and slide presentation will review the pathophysiology, diagnosis, and management of Respiratory Distress Syndrome. There will also be a discussion on long term outcomes and new modes of therapy.

3:45

"Fetal Intervention"
Federico G. Mariona, MD, Professor, Director, Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, Wayne State University/Hutzel Hospital

Modern technology facilitates the detection of a number of fetal anomalies and illnesses. An accurate understanding of the pathophysiology of fetal disease allows selective fetal intervention. Since genetic therapy is an expected reality, crucial issues involving mothers and fetuses must be resolved.

"Respiratory Distress in the Term Infant"
Alfred W. Brann, Jr., MD, Professor of Pediatrics and Director, Division of Neonatal-Perinatal Medicine, Emory University School of Medicine, Atlanta

This talk will focus on the differentiation of the three leading causes of respiratory distress in term newborns-meconium aspiration, group B streptococcal sepsis and persistent pulmonary hypertension of the newborn.

4:15

"Risk Management-History and Status"
Gerald H. Mandell, MD, Speaker, Michigan State Medical Society House of Delegates; Chairman, Department of Laboratory Medicine, Sinai Hospital of Detroit

The status of the Medical Associations for Risk Management (MARM) will be presented from a historical, structural, and functional view with particular emphasis toward problem solving in perinatal health care management.

"Extra Corporeal Membrane Oxygenation"
Robert H. Bartlett, MD, Professor of Surgery, University of Michigan Medical School

ECMO is now used in several neonatal centers as the treatment of choice for term infants with respiratory failure unresponsive to conventional management. The success of this technique establishes prolonged extracorporeal circulation as a definitive means of treatment in reversible vital organ failure.

4:45

Adjourn to Poster Session

Adjourn to Poster Session

Thursday Morning, March 26

Concurrent Sessions in A) Obstetrics and B) Pediatrics

OBSTETRICS: "Controversies"

Moderator: Joseph P. Metz, MD, Conference Co-chairman, Associate Director, Obstetrics and Gynecology, Hurley Medical Center, Flint; Associate Professor, Michigan State University College of Human Medicine

8:15

"Biophysical and Doppler Flow Parameters of Fetal Well-Being"
Alan Bocking, MD, Assistant Professor, Department of Obstetrics and Gynecology, University of Western Ontario, St. Joseph's Hospital, London, Ontario

In utero physical examinations of the unborn are considered state-of-the-art. Biophysical and doppler flow parameters can assist in determining fetal compromise/fetal well-being.

8:45

"Post-Date Pregnancy: Induce"
Norman F. Gant, MD, Professor, Department of Obstetrics and Gynecology, University of Texas Southwestern Medical School, Dallas

Because of the striking increase in perinatal mortality in the truly post-date pregnancy, intervention should be encouraged.

9:15

"Post-Date Pregnancy: Wait"
Michael Varner, MD, Associate Professor, Department of Obstetrics and Gynecology, University of Iowa College of Medicine, Iowa City

Because of vagaries in pregnancy dating, only a small fraction of the estimated 5-7% of post-date pregnancies are truly prolonged. To avoid unnecessary intervention, proper assessment with presently available techniques needs to be advocated.

PEDIATRICS: "Controversies in Newborn Management"

Moderator: Stanford A. Singer, MD, Southfield, President, Michigan Chapter, American Academy of Pediatrics

8:15

"The Dilemma of Jaundice in the Healthy Newborn Infant"
M. Jeffrey Maisels, MD, Chairman, Department of Pediatrics, William Beaumont Hospital; Clinical Professor of Pediatrics, University of Michigan Medical School

To the pediatrician and the family practitioner, jaundice remains the most common and, perhaps the most vexing, problem in the well baby nursery. Definitions of physiologic jaundice found in current texts have created a class of healthy, jaundiced, infants with "non-disease." Awareness of the factors that affect bilirubin levels permits a more rational approach. A new definition of physiologic jaundice is needed.

8:45

"Early Discharge Equals the Right Discharge: Program Considerations and Future Trends"
Chandice Covington Harris, RN, MSN, Doctoral Candidate, School of Nursing; Research Assistant, Department of Family Practice; University of Michigan

This presentation highlights the evaluation which must occur to determine cost and health benefits and promote standardization of early postpartum discharge. The future need for postpartum and nursery liaison nurses is examined.

9:15

"Vitamin E in the Neonate"
William A. Engle, MD, Assistant Professor of Pediatrics, Section of Neonatal-Perinatal Medicine, Indiana University School of Medicine, Indianapolis

Vitamin E has been administered therapeutically for a variety of neonatal illnesses. The physiology of oxygen radicals and the antioxidant function of vitamin E, the role of vitamin E in treatment of retinopathy of prematurity, bronchopulmonary dysplasia, intracranial hemorrhage, and the complications of vitamin E therapy will be discussed.

Thursday Morning, March 26, continued

	Obstetrics, continued	*Pediatrics, continued*
9:45	**Question & Answer Session**	**Question & Answer Session**
10:00	**Break**	**Break**
10:15	**"Vaginal Birth After Caesarean"** **Clinton H. Dowd, MD,** Professor, Department of Obstetrics and Gynecology, Michigan State University College of Human Medicine; Director, Obstetrics and Gynecology, Hurley Medical Center, Flint As an alternative to repeat Caesarean section, attempted vaginal delivery is a viable option. Controversies, selection of patients and factors leading to a favorable outcome will be discussed.	**"SIDS: 1987 Perspective"** **Carl E. Hunt, MD,** Professor and Vice Chairman, Department of Pediatrics, Northwestern University Medical School; Head, Division of Neonatology and Director, Sleep Laboratory, Children's Memorial Hospital, Chicago The pathophysiology of SIDS remains unknown. Appropriately designed and well-controlled prospective studies are needed in asymptomatic at-risk infants to determine the non-intervention rate of SIDS and the extent to which any intervention lowers this rate.
10:45	**"New Reproductive Technologies"** **Marilyn Poland, RN, PhD,** Associate Professor of Obstetrics and Gynecology, Wayne State University School of Medicine In light of advances in ultrasonography, chorionic villus sampling, fetal surgery and caesarean section, the legal, ethical and social changes in how one views mothers' rights, will be discussed.	**"Breast Feeding"** **Sarah Coulter Danner, RN, MSN, CNM,** Instructor, Maternal/Child Nursing, Case Western Reserve University; Director, Lactation Clinic, Cleveland; Private Practice, Western Reserve Nurse-Midwifery Associates The mechanism of sucking and its common disorders will be reviewed. Breast feeding infants with cleft defects and facial hypotonia, controversies such as nipple confusion, breast feeding premature infants and supplying formula discharge packs will be discussed.
11:15	**"Maternal Serum Alpha Fetoprotein Screening: The Real Story"** **Mark I. Evans, MD,** Director of Division of Reproductive Genetics, Wayne State University School of Medicine/Hutzel Hospital and President, Fetal Medicine and Surgery Society Maternal serum alpha-fetoprotein testing (MSAFP) has been used successfully for prenatal detection of neural tube defects for 15 years. The use of low MSAFPs for detection of chromosome anomalies is newer. Though preliminary data are encouraging, there are confounders of interpretation. Possible implications of its use will be presented.	**"The Syndrome of Neonatal Polycythemia-Hyperviscosity—Does it Exist?"** **Robert E. Schumacher, MD,** Assistant Professor, Department of Pediatrics and Communicable Diseases, Section of Newborn Services, University of Michigan Medical School Although an association between neonatal polycythemia-hyperviscosity and multisystem organ failure has been demonstrated, in most instances a cause and effect type of relationship has not. This talk will serve to highlight what is known about this "common problem" of the newborn.
11:45	**Question & Answer Session**	**Question & Answer Session**

Thursday Afternoon, March 26

12 NOON
Adjourn to Luncheon Meetings:
(all concurrent sessions)

"Feeding the Low Birth Weight Infant"
William A. Engle, MD, Assistant Professor of Pediatrics, Section of Neonatal-Perinatal Medicine, Indiana University School of Medicine

Nutrition in low birth weight infants is constantly improving. We will review the physiology of nutrition in low birth weight infants, and discuss the currently available formulas.

"A New Look at Intraventricular Hemorrhage"
Seetha Shankaran, MD, Associate Professor, Department of Pediatrics, Wayne State University School of Medicine; Associate Neonatologist, Children's Hospital of Michigan and Hutzel Hospital, Detroit

Intraventricular hemorrhage continues to be a leading cause of neurologic disability among premature infants. The evolution of diagnostic techniques and measures aimed at prevention will be presented.

"Pre-eclampsia"
Norman F. Gant, MD, Professor, Department of Obstetrics and Gynecology, University of Texas Southwestern Medical School, Dallas

"Prophylactic Antibiotics for Caesarean Section"
Michael Varner, MD, Associate Professor, Department of Obstetrics and Gynecology, University of Iowa College of Medicine, Iowa City

Prophylactic antibiotics may be of value in patients undergoing caesarean section following labor or ruptured membranes even if there is no evidence of infection. The appropriate antibiotic should be safe, inexpensive, effective against the majority of organisms, and not routinely utilized for severe infections.

"Outreach Programs for Hard-to-Reach Pregnant Women"
Marilyn Poland, RN, PhD, Assistant Professor, Department of Obstetrics and Gynecology, Wayne State University School of Medicine

This presentation will summarize findings from a recent study of the factors underlying why some women fail to receive prenatal care. It also describes programs developed to encourage health care.

1:30
General Session: "Perinatal Brain Impairment"
Moderator: Preston V. Dilts, Jr., MD, Bates Professor and Chairman, Department of Obstetrics and Gynecology, University of Michigan Medical School

1:45
"How and When Brain Damage Takes Place Before Birth"
Richard L. Naeye, MD, Professor and Chairman, Department of Pathology, The Pennsylvania State University School of Medicine, Hershey

Many seem to believe that asphyxia during labor and delivery is a frequent cause of neurologic abnormalities in children. This assumption needs to be challenged. Recent findings suggest that intrapartum hypoxia is rarely a cause of long term neurologic abnormalities.

2:30
Break

2:45
"Obstetric Considerations in Perinatal Brain Impairment"
Kenneth R. Niswander, MD, Professor, Department of Obstetrics & Gynecology, University of California at Davis, Sacramento

To what extent can obstetrical care, especially intrapartum care, be held responsible for cerebral palsy? A review of the possible causes of cerebral palsy will be followed by a report of experiments to test the hypothesis that obstetric intervention can reduce the risk of cerebral palsy.

3:30
"Pediatric Considerations in Perinatal Brain Impairment"
Alfred W. Brann, Jr., MD, Professor of Pediatrics and Director, Division of Neonatal-Perinatal Medicine, Emory University School of Medicine, Atlanta

A significant degree of intrapartum asphyxia for a period of time long enough to produce signs of significant neurologic dysfunction in the neonate can lead to cerebral palsy with associated mental retardation and seizures. However, data do not support that this type of episode is a frequent primary cause of cerebral palsy.

Thursday Afternoon, March 26, continued

4:15
Question & Answer Session

4:30
Conference Adjourns

The Maternal and Perinatal Health Conference Planning Committee

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26th Annual Michigan Conference on Maternal and Perinatal Health

March 25 & 26, 1987 Hyatt Regency Dearborn

Wednesday Morning, March 25—General Session: "Preparing for the 90's"

7:30	Registration
8:15	Welcome
8:30	"Prospects for Reducing Perinatal Mortality"
9:15	"Low Risk Management of High Risk Labor"
10:00	Break
10:30	"Women's Health Care in the Year 2000"
11:15	"Can You Read?"
12 NOON	Adjourn to Luncheon Meetings

Wednesday Afternoon—Concurrent Sessions in A) Obstetrics and B) Pediatrics

OBSTETRICS: "What's Hot"		PEDIATRICS: "Respiratory Distress Revisited"
"AIDS"	1:30	"Recognition of Respiratory Distress"
"Maternal Trauma"	2:00	"Resuscitation of Newborns"
"Fetal Trauma"	2:30	"Monitoring Critically-Ill Newborns"
Break	3:00	Break
"Prevention of Premature Labor"	3:15	"RDS: Review and Preview"
"Fetal Intervention"	3:45	"Respiratory Distress in Term Infants"
"Risk Management"	4:15	"Extra Corporeal Membrane Oxygenation"
Adjourn to Poster Session	4:45	Adjourn to Poster Session

Thursday Morning, March 26—Concurrent Sessions in A) Obstetrics and B) Pediatrics

OBSTETRICS: "Controversies"		PEDIATRICS: "Controversies in Newborn Management"
"Fetal Well-Being"	8:15	"The Dilemma of Jaundice"
"Post-Date Pregnancy: Induce"	8:45	"Early Discharge"
"Post-Date Pregnancy: Wait"	9:15	"Vitamin E in the Neonate"
Question & Answer Session	9:45	Question & Answer Session
Break	10:00	Break
"Vaginal Birth After Caesarean"	10:15	"SIDS: 1987 Perspective"
"New Reproductive Technologies"	10:45	"Breast Feeding"
"Maternal Serum Alpha Fetoprotein"	11:15	"Neonatal Polycythemia-Hyperviscosity"
Question & Answer Session	11:45	Question & Answer Session
Adjourn to Luncheon Meetings	NOON	Adjourn to Luncheon Meetings

Thursday Afternoon — General Session: "Perinatal Brain Impairment"

1:30	Introduction
1:45	"How and When Brain Damage Takes Place Before Birth"
2:30	Break
2:45	"Obstetric Consideration in Perinatal Brain Impairment"
3:30	"Pediatric Considerations in Perinatal Brain Impairment"
4:15	Question & Answer Session
4:30	Conference Adjourns

Advance Registration For Michigan Conference on Maternal and Perinatal Health

Name____
(please print) (first) (initial) (last)

Address____

City, State__________________ Zip__________ Phone______________

MSMS Member: Yes______ No______ Specialty______________________

Nurse______ Resident______ Other______________________________

Tuition Schedule

Physicians: $45 each General Session
Nurses: $35 each General Session
Others: $35 each General Session
Residents & Students: No Charge for General Session
Luncheon: $10 for All Registrants

Wednesday, March 25, 1987

☐ General Session (incl. Concurrent) $_____

☐ Luncheon Meetings (indicate 1st & 2nd choices): $_____
- _____ Surrogate Pregnancy
- _____ Infant Mortality
- _____ Maternal/Child Advocacy
- _____ Premature Rupture
- _____ Perinatal Loss/Bereavement

☐ Concurrent Sessions, Choose *one*
- _____ A: Obstetrics
- _____ B: Pediatrics

Wednesday Total = $_____

Thursday, March 26, 1987

☐ Concurrent Sessions, Choose *one*
- _____ A: Obstetrics
- _____ B: Pediatrics

☐ Luncheon Meetings (indicate 1st & 2nd choices): $_____
- _____ Feeding/Low Birth Infant
- _____ Intraventricular Hemorrhage
- _____ Pre-eclampsia
- _____ Prophylactic Antibiotics
- _____ Outreach Programs

☐ General Session (incl. Concurrent) $_____

Thursday Total = $_____

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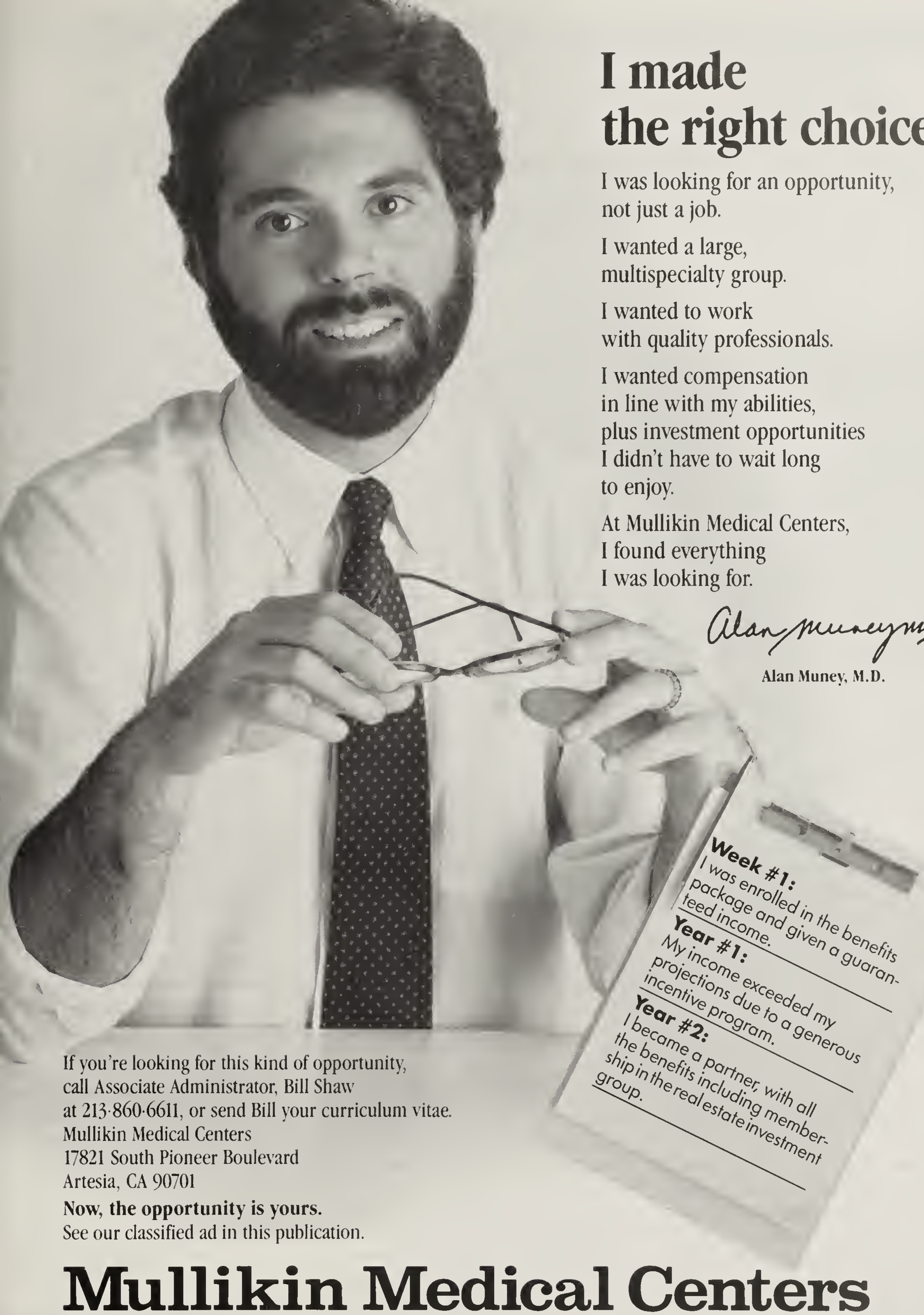

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Physician discipline: the process explained

Thomas J. DeKornfeld, MD

How does the Michigan Board of Medicine disciplinary process work? Let me share with you some of the difficulties confronting the Board and suggest some ways in which you could assist in this important function.

The first point to remember is that the Board can take no action in a matter about which it has no information. Somebody has to make an allegation against a physician before the regulatory process can get under way. This allegation can come from a patient, from another physician, from a hospital, from the Insurance Bureau, from a law enforcement agency or from the court system. There is also a developing interstate system which will advise Boards about actions taken against a licensee in another state. To date, consumers make the majority of allegations. The professions and the hospitals, which at least in theory should be most informed and most concerned, have been spectacularly reticent in sharing their information with the Board.

When the Board of Health Services receives an allegation, it refers the charge to the Investigations Division. That division reviews and presents all charges to the Allegations Investigation Committee of the Board. This committee carefully assesses each charge and divides them into three groups. Many of the allegations have no merit. These are declined by the Board, and the person making the allegation is so informed. Some of the allegations may be meritorious but are so vague that the Board is in doubt. In these cases, the Board requests additional information. This additional information may be the hospital or office record, or further discussion with the person making the allegation. A small portion of the charges report potentially serious violations of the Public Health Code. The Board refers them to investigation and they are sorted into immediate, urgent and routine groups. In rare cases, but where there is a definite threat to the public health, welfare and safety, a high priority investigation will lead to a summary suspension of the physician's license. This order is issued by the Board and takes effect immediately. Following the suspension, the physician is granted a hearing and due process takes its course. Summary suspensions usually result where there is serious alcohol or controlled substance abuse, an where continued practice may indeed jeopardize patients.

In ordinary cases, after the investigation has documented tha the physician in all probabilit has violated the Code, the attorney general, on behalf of the people of Michigan, will file a complaint against the physician.

The next step

The next step is the complianc conference. This is an informa meeting between an assistant attorney general, the physicia and/or attorney, and a representative of the Board.

The compliance conference allows the physician and/or a representative to meet with the assistant attorney general. If th facts of the case are contested, th matter is scheduled for hearing If the physician acknowledges th violation he/she may agree t some sanction voluntarily. If th physician consents to a sanction. a "consent order" will be drafte by the attorney general. Thi consent order is then submitte to the Board and put into effect.

Cases go to formal hearing before an administrative law hearing officer. This hearing is a formal affair, very similar to a regular trial. Both the physician and the state can call witnesse

Continued on page 16

The author, Thomas J. DeKornfeld, MD, is administrator, Michigan Board of Medicine.

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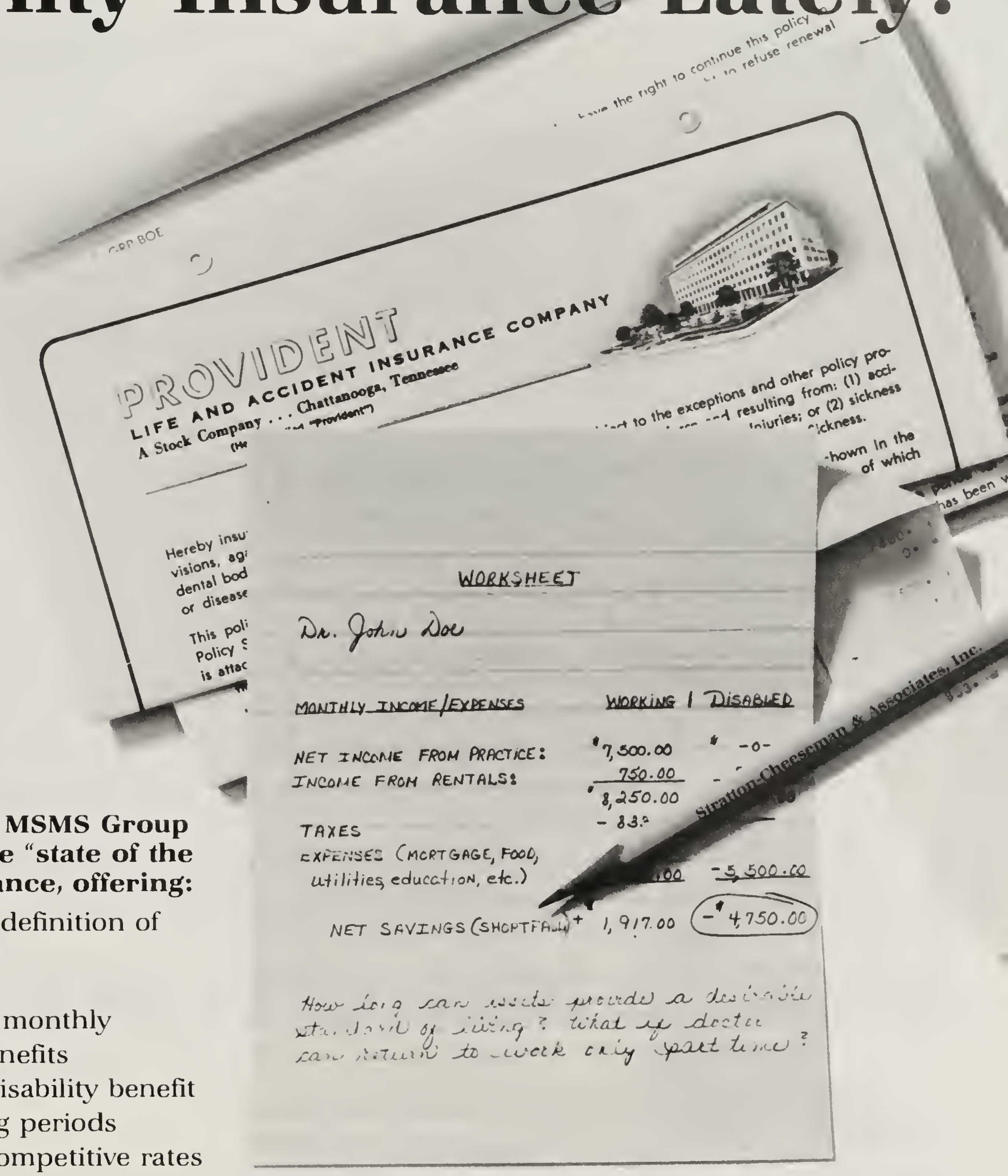
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DISCIPLINE/Continued

who testify under oath. Both sides can cross examine and both sides can make opening and closing statements. Afterwards, the hearing officer will draft the "findings of fact and conclusions of law." This document is an analysis of the evidence presented and the legal conclusions of the hearing officer as to whether the physician has violated the pertinent sections of the Code.

This document and the entire hearing transcript is distributed to every Board member for review. Occasionally these records are voluminous and in at least one memorable instance, involved more than 2,000 pages. The case is then placed on the Board agenda. At this time the Board can accept or reject the findings of fact and/or conclusions of law. On motion then, a sanction is proposed and, if supported and passed, takes effect upon signing by the chairperson of the Board, or at a specified time in the near future.

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The sanctions which the Board can impose range from a reprimand to suspension, or revocation of the license. The Board also can put limits on the license, assign a probationary period and impose a fine.

In my relatively short period of service to the Board, I have been enormously impressed with the seriousness and dedication with which the Board members approach this task. First of all, the time required to prepare for discussion may be considerable. Reading the transcripts takes many hours and yet the members do it conscientiously and are well prepared for action.

Much at stake

Sitting in judgement over a fellow physician is an awesome responsibility. Careers are at stake, reputations are at stake, livelihoods are at stake, families' happiness is at stake. Yet the Board is willing to take on this responsibility and discharges it as fairly and as equitably as possible. If any of you believe that serving on the Board is all fun and games, I invite you to attend a meeting sometime. I believe you would find it an interesting and impressive experience.

In my next column I will discuss some of the other regulatory matters with which the Board deals and I will give you some statistics about action taken during the past year.

I trust all of you had a pleasant and relaxing holiday season and that the new year will be a happy, healthy and trouble-free one for you and for your loved ones. ☐

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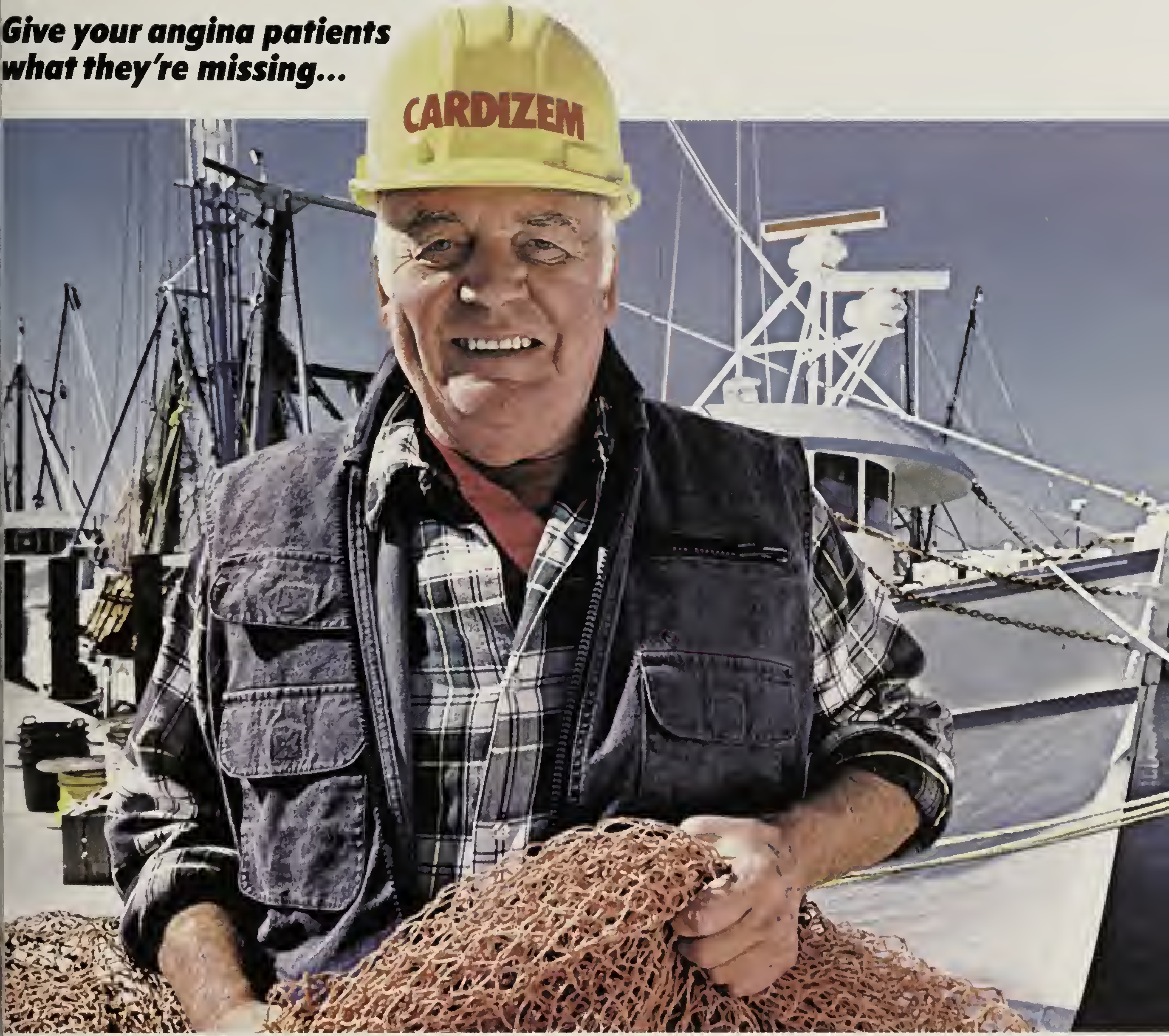

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***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.

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Brief Summary
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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

See complete Professional Use Information before prescribing.

References: 1. Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347. **2.** Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984;24(Dec):150-159. **3.** Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687. **4.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. **5.** Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.

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Litigation is a crippling disease

The Michigan Association of the Professions recently hosted a Presidents Roundtable discussion. These timely remarks were made by Carl A. Gagliardi, MD, MSMS president-elect:

When I was asked to be a participant in this roundtable, it was suggested that I discuss the principal concern facing the medical profession in the near future. That certainly made it easy for me to choose my topic. What is it that dominates physicians' conversations with each other? What is it that is driving physicians into thoughts of early retirement or a switch from patient care to some other branch of medicine? What is it that is making bright young residents look for places outside of Michigan in which to live, practice and serve? What is it that will ultimately cause a deterioration in the quality of care and make patients and physicians adversaries instead of advocates for each other? What else but litigation and more litigation?

The irony of all this is that we are surely in the golden age of medicine in this country. Technology is moving at an astounding pace. Life expectancy continues to grow and at the same time, we strive to improve the quality of that longer life: just look around you to see some of the results. Children rarely die from infections such as pneumonia, diarrhea, meningitis, polio, measles, tetanus, whooping cough and many other infections. We are working hard to conquer hormonal disturbances, and soon we may have a cure for diabetes. Kidney transplants have become almost routine while liver, heart and other transplants are becoming more and more feasible.

Then if you need to be convinced even more, look at what is happening in maternal-fetal medicine. High risk centers for mothers offer a degree of skill unknown or unheard of only a few years ago.

Despite these gains, almost every doctor now can look forward to at least one lawsuit during his professional career. One out of every four doctors is sued every year. The involvement in such cases has little relationship to one's training or ability but rather depends upon the degree of risk a physician is willing to face.

Let us look at Michigan, this most litigious state. We have the distinct dishonor of having an infant mortality rate in Michigan which is a disgrace, and the city of Detroit has the dishonor of having the worst or the second worst rate for larger cities in this country.

Why is this true? Why? There are many causes—some are societal and some are medical. If one looks at infant mortality one can see a distinct increase in risk depending on whether:

- Mother is unmarried;
- Mother is a young teenager;
- Mother has dropped out of school;
- Mother has been on drugs or alcohol or smokes;
- Mother has had less than five prenatal visits.

As a society and as a medical profession, we need to address this problem. Not many among us would choose poverty, possible disability, and even death for our children if we knew better. We must reach this generation of teenagers lest we lose not only this generation, but a large portion of the next. So we need education, and we need the best medical care for this high risk group of mothers and their newborns.

How does litigation enter into this problem? Any obstetrician who is willing to take part in the solution of this terrible dilemma faces the risk of unfavorable outcomes followed by hefty lawsuits. Obstetricians are becoming more and more unwilling to accept patients who are not previously known to them. Where will these young people go for care? If this trend continues and the liability crisis remains unabated, who will be their advocates?

Redress

This year the medical society spent a major portion of its energy and resources to seek redress from our state legislators. Although they, too, worked long and hard on the problem, the reforms that they enacted appear to have little effect so far. The

Continued on page 20

LITIGATION/Continued

cap on non-economic awards is meaningless. The statute of limitations still holds physicians hostage for at least 15 years. There is no real relief on frivolous suits, and the contingency fee schedules remain obscene!

Let me announce loud and clear that we are not happy, and we are not through. This problem needs considerably more work. We will return again and again until there is meaningful relief. My children and grandchildren and yours need a healthy, vigorous medical care system and not one crippled by our legal process.

I declare that any system which absorbs more than 70 percent of the available funds for legal fees and other expenses and leaves less than 30 percent for patient compensation is a bankrupt, immoral system. How a compassionate society can continue to tolerate such abuse is more than I can understand.

If society declares that it will not walk away from any injured patient, regardless of the cause, we need to look at more efficient ways of addressing the problem. Incompetent physicians need to be under the jurisdiction of the Board of Medicine. Impaired physicians need to be helped in recovery as much as possible. Physicians involved in criminal activity need to be handled in the criminal justice system.

The tort system as we use it now will not protect patients but rather it will destroy the best medical care system in the world. Yes indeed, my friends, there is trouble in River City. ☐

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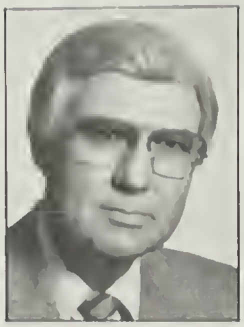
Sawyer

Stanisavljevic

Treisman

Stanko Stanisavljevic, MD, Royal Oak, was named a member of the board of trustees of the Orthopedic Research and Education Foundation. ...**Winford Quick, MD,** medical director of Central Foundry Division of General Motors Corporation was appointed to a three-year term on the board of directors of Saginaw County Substance Abuse Services. ...**Stephen P. Cass, MD,** Pleasant Ridge, received the 1986 Norwich Eaton Pharmaceuticals Resident Research grant for nearly $10,000 to research ear surgery. **J. Elmer Mueller, MD,** Birmingham, was elected to the Board of Trustees of William Beaumont Hospital. ...**William Emery, MD,** St. Joseph, closed his medical practice after 35 years. He will devote his time to his position as director of corporate health affairs for Whirlpool Corporation. ...**Ralph Wadley, MD** (deceased) was honored by *Town & Country* magazine for his $1.7 million gift to Albion College. Doctor Wadley's estate has endowed the Ralph Wadley, MD, Scholarship Fund to aid academically promising and financially needy premed students at the college. ...**Boy Frame, MD,** Grosse Pointe Park, participated with four other specialists in compiling the question and answer pamphlet, "Five Specialists Discuss the Long-Term Management of Paget's Disease of Bone," released by Norwich Eaton Pharmaceuticals, Inc. ...**John R.F. Ingall, MD,** Detroit, has launched the "International School for Cancer Care," a program to fight cancer on a worldwide scale. ...**Howard J. Sawyer, MD,** Southfield, has been elected president of the Michigan Occupational Medical Association. Doctor Sawyer is chairman of the Oakland County Medical Society Occupational, Environmental and Public Health Committee. The Michigan Society of General Surgeons has elected the following officers for 1987: **Frederick E. Ludwig II, MD,** Sault Ste. Marie, president; **E.J. Treisman, MD,** Southfield, president-elect; **James W. Copping, MD,** Port Huron, secretary/treasurer. ...**Jose Evangelista, MD,** Livonia, was elected president-elect of the Association of Phillippine Physicians in America (APPA) for 1986-87. □

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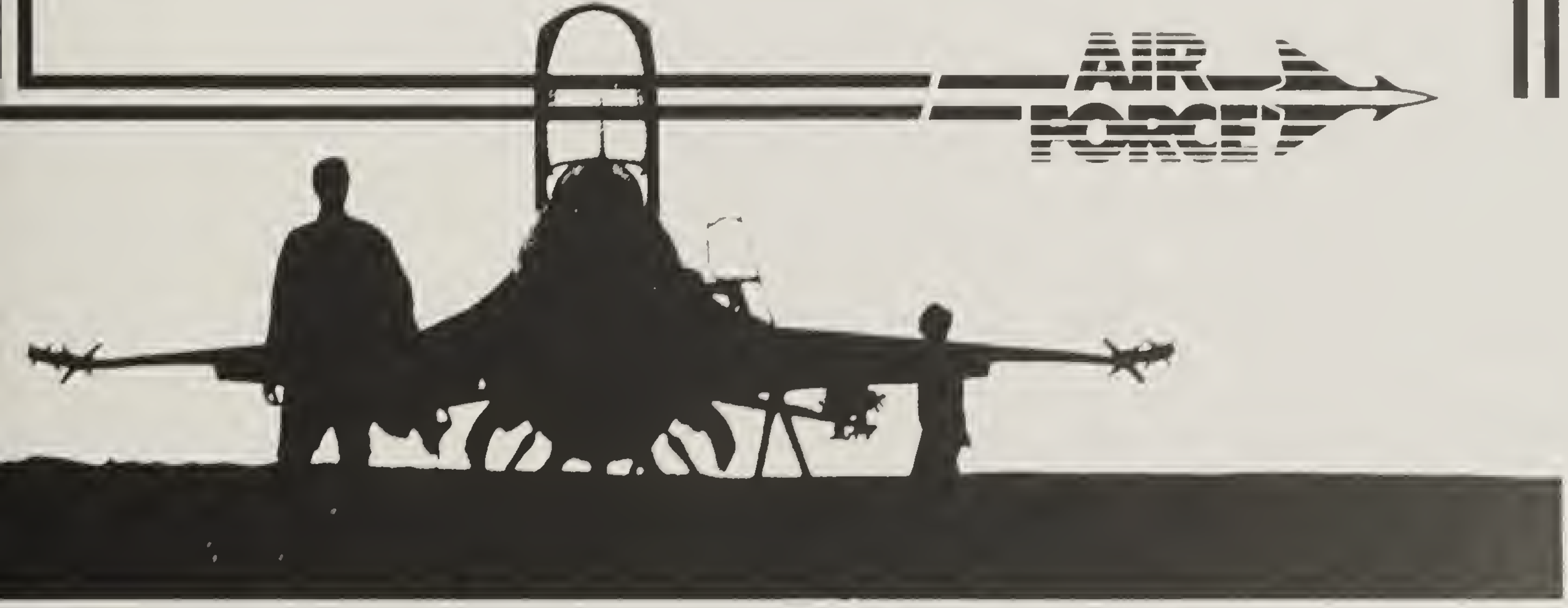

DEATHS

Gene C. Cunningham, MD
Martinsville, Indiana

Doctor Cunningham, formerly of Kalamazoo, died October 14 at the age of 66. He received his medical degree in 1953 from the Indiana University School of Medicine. Doctor Cunningham served in the US Coast Guard from 1943-1946. His primary specialty was Occupational Medicine, and he was employed by the Upjohn Company.

Walter DiGiulio, MD
Detroit

Doctor DiGiulio died September 30 at the age of 53. He was on staff at St. John Hospital, specializing in thyroidology and nuclear cardiology. Doctor DiGiulio received his medical degree from St. Louis University in 1959. He served his residency at St. Louis University Hospital.

Willis A. Hasty, MD
Shelby

Doctor Hasty died October 8 at the age of 71. He received his medical degree from the University of Michigan in 1939. Doctor Hasty served in the US Army for four years with the rank of Captain at a convalescent hospital in France. In 1946 he became chief of staff at Shelby Hospital, and he served many years as Oceana County coroner. Doctor Hasty retired from practice in 1980.

William Heard, MD
Grand Haven

Doctor Heard died March 20 at the age of 83. He received his medical degree from Queens University in Ontario, Canada. Doctor Heard was retired from practice and from the staff of Municipal City Hospital in Grand Haven.

Richard Potter, MD
West Branch

Doctor Potter died October 11 at the age of 62. He received his medical degree from Jefferson Medical College in 1948. Doctor Potter was Marquette County Health Department Director from 1966-1980. He received a Michigan State Medical Society President's citation in 1980 for his service to the Statewide Health Coordinating Council and the Upper Penninsula Health Systems Agency.

Earl S. Rhind, Sr., MD
Holland

Doctor Rhind died September 28 at the age of 81. He received his medical degree from the University of Oregon Medical School in 1933. Doctor Rhind was retired from practice and from the staff of War Memorial Hospital in Sault Ste. Marie, and was a past-president of the Chippewa-Mackinac County Medical Society.

William Schaefer, MD
Midland

Doctor Schaefer died October 15 at the age of 72. He received his medical degree from the University of Pittsburgh Medical School in 1939. Doctor Schaefer's primary specialty was physical medicine and rehabilitation. He served in the US Army from 1941-1946 as a Captain, and was on staff at Midland Hospital Center.

A.L. Hubert Verwys, MD
Grand Rapids

Doctor Verwys died October 15 at the age of 70. He received his medical degree from the University of Michigan in 1942. Doctor Verwys semi-retired in July from the staffs of Butterworth Hospital and Blodgett Memorial Medical Center. He maintained a private practice in Grand Rapids which was restricted to gynecology. Doctor Verwys served as a general officer in the US Air Force from 1944-1946.

Ralph D. Wigent, MD
Pontiac

Doctor Wigent died February 22 at the age of 75. He received his medical degree from Indiana University School of Medicine. Doctor Wigent was the school physician for Oakland University for five years, and his primary specialty was industrial medicine. Doctor Wigent served in the US Army from 1944-1946.

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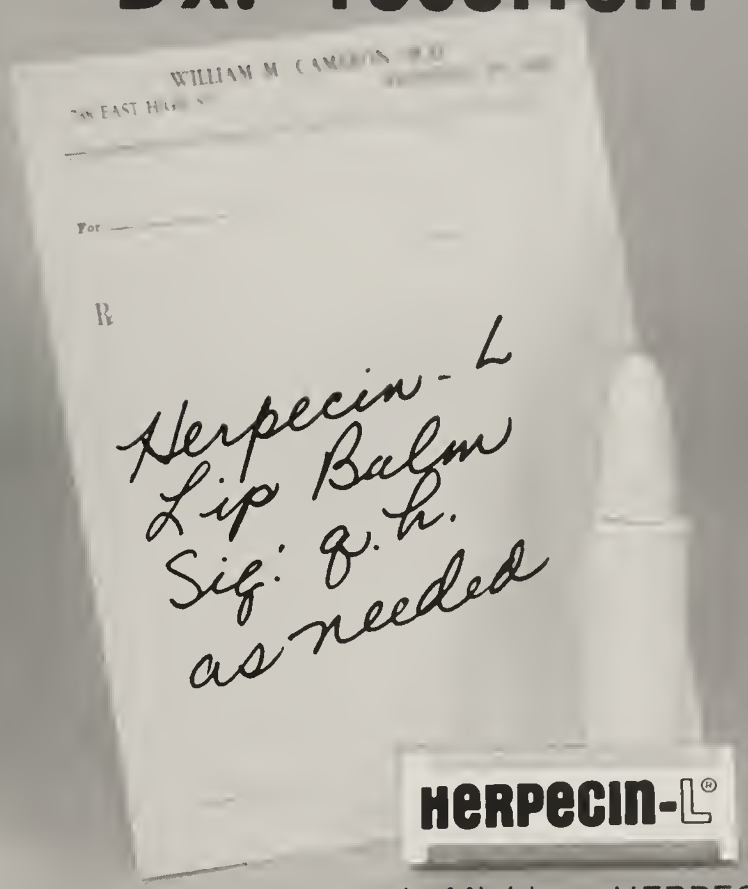

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Doctors, hospitals, and the new health care: A joint adventure

Since leadership is the key variable in shaping the future, I want to share some thoughts with you on "the new health care" and what's ahead for doctors and hospitals. Also, I'll make suggestions about how we might work together to exert leadership on the complex issues facing us.

The new health care

The new health care is a euphemism for the competition that we see now among the providers of medical care services. The switch from a regulatory approach to a competitive approach obviously carries with it some changing political philosophy. For example, in the mid-1960s it was established by the government that equal access to quality health care, regardless of ability to pay, was a social right; by contrast, current governmental philosophy views health care primarily as an economic concern, where price has become the proxy for value and limitation is a reality. This has resulted, as we all know, in a great deal of turmoil for health care providers.

In the September 18, 1986, edition of the *New England Journal of Medicine*, Columbia University economist Eli Ginsberg referred to this new era in his article, "The Destabilization of Health Care." He points out that health care endured a remarkable stability between the period of the Flexner Report in 1910 and the mid-1960s. This was because of three factors, according to Ginsberg: dominance of physicians, local sponsorship of community hospitals, and the practice of cross-subsidization for care of the poor. Because of these factors, health care flourished into a system— a system with problems, albeit, but a system. At the same time, during the last two decades destabilizing forces have attacked this pluralistic health care system. These destabilizing forces are: government financing for Medicare and Medicaid, concomitant government regulation, and finally, the introduction of competition in the early 1960s.

Impact: hospitals and doctors

Now, let's take a look at the impact of the new health care on hospitals and physicians.

In hospitals, we observe the following: fewer numbers of occupied hospital beds, consolidation of free-standing hospitals into multi-hospital systems and health care corporations, sicker patients being admitted to the hospital, and the exodus of certain services and technology from the hospital to nonhospital settings.

For doctors, the primary impact is a continuing loss of independence. Factors that are affecting this change include: the unchecked increase in the cost of malpractice insurance, decreased opportunities for residency programs, the introduction of capitated payments and managed care, and finally the increased numbers of physicians.

But, there are also some myths that accompany the new health care competitive environment. The first of these is the battle of the health care corporations. It has been suggested by health care futurists that only a handful of national corporations will eventually deliver all the health care in the United States. However, developments in recent months make this unlikely. First of all, there are not enough national contracts to support many national health care delivery organizations. This is because in the final analysis health care is a local product, that is, delivered by health care professionals selected by residents of a locality, and accountable to local purchasers and consumers. In the future, it is most likely that a petition will occur among regionally developed health care systems, not national systems. At the same time, there is the myth that Blue Cross and Blue Shield of Michigan is in considerable danger of losing market share to health care delivery organizations based outside of Michigan. In my opinion, this is highly unlikely, both because of the scenario that I have just outlined and the fact that the BCBSM discount still holds a significant competitive edge. Also, it is likely that BCBSM will enter into selective contracting with

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The author, Spencer C. Johnson, is president of the Michigan Hospital Association. He made these remarks at the 1986 MSMS Public Affairs Leadership Conference.

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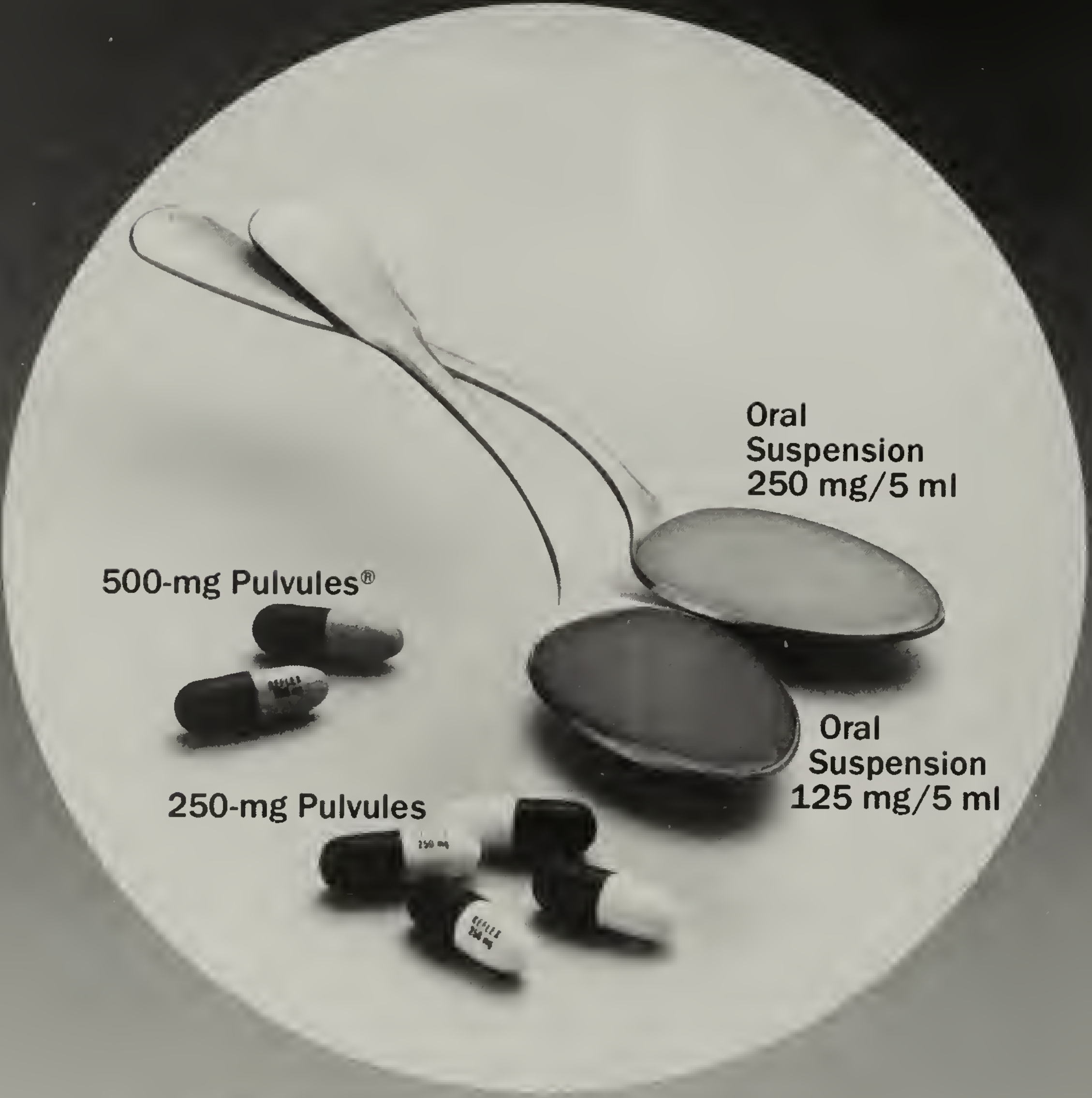
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JOINT ADVENTURE/Continued

health care providers during the next few years, which will increase the sense of competition even more.

Another myth that we have confronted this year is the issue of privatization, that is, taking government out of the business of providing or managing the financing and delivery of health care. In Michigan, this was embodied in the suggestion that EDS take over management of the Medicaid program. While I think it is unlikely that in a state like Michigan private corporations will take over the management of prisons, the education system or the health care delivery system, it is not unlikely that this will serve to drive policy makers more rapidly toward capitation and vouchers as cost control measures.

The ultimate myth of the competitive environment is that true competition is the answer to the complex cost, quality and access issues facing us. On the other hand, one could make the argument that our pursuit of competition could actually result in a health care system similar to the British socialized medicine model. The British, in their attempt to balance limited resources with rising health care expectations, instituted the National Health Service. The main features of the Service include:

- A universal right to care.
- An established minimum level of care.
- No choice of physician or hospital.
- Delays (sometimes considerable) in non-urgent care.
- Few comforts and amenities.
- Strict limits on the use of expensive, high-technology medicine based on moral and ethical judgments.

Because of the limitations of the system, one of the most significant trends in British health care is toward the purchase of private health care. Private insurance is expected to grow rapidly through the 1980s and 1990s so that a two-tiered health care system is all but assured in Britain by the late 1990s.

Thus, if we implement similar criteria in our cost-conscious competition model we are, in fact, following a parallel stream of logic that led the British to socialized medicine.

Finally, while the competitive approach is being touted, we must realize that like other promising health care financing proposals, competition still leaves us with some serious public policy challenges: meeting the needs of special populations such as the aged, the poor, and children; quality of care; malpractice; medical education, and technology and ethics. In fact, the greatest argument for a regulated system is the ability to meet the public interest by directing resources and attention to these areas.

Michigan health care providers have taken up the challenge to restructure health care delivery, but the challenge is not theirs alone. Reinventing health care means innovative approaches and regulatory flexibility while maintaining our human service mission. The community, working with providers, will help define the quality and level of services to be delivered. And, finally, state government must be willing to loosen the regulatory constraints it has placed on hospitals over the last decade in the hopes of controlling health care costs.

The MHA is advocating significant reform of the state's certificate of need program. It is our belief that access to effective, appropriately priced health care is actually being restricted by the program currently in place in Michigan. The Michigan Hospital Association urges MSMS to join us in our efforts to raise certificate of need thresholds, streamline the health planning process, and expedite the processing of appeals that eventually occur under such a regulatory program.

In the area of data—once entirely the province of health care providers— purchasers, regulators, consumers and even the media are becoming more involved in the evaluation and publication of health care data. This usually involves three aspects: utilization control, price comparison, and quality evaluation. Currently in the state of Michigan there are several efforts on-

Continued on page 30

JOINT ADVENTURE/Continued

going in the data area: a call for government regulation and disclosure of data; purchaser coalitions for the collection, analysis and dissemination of data, and provider initiatives to do the same.

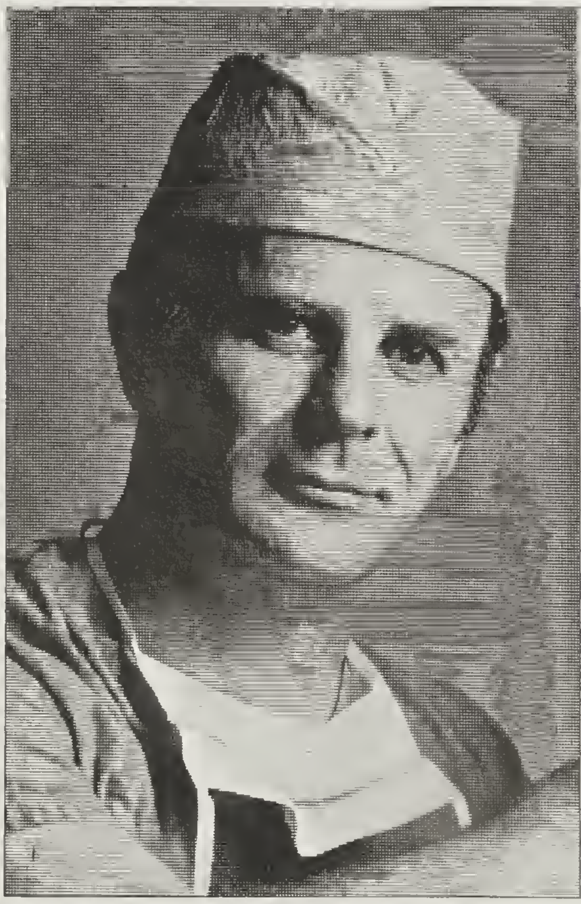
The Michigan Hospital Association and the Michigan State Medical Society, between them, have the capacity to rationalize activities in this arena and develop meaningful approaches for Michigan.

On the issue of malpractice, again, we must join forces to continue to seek the reforms that eluded us in this legislative session. The exceptions to the $225,000 cap must be deleted, the statute of limitations improved, and the ability of hospitals and doctors to function freely on behalf of their patients without unnecessary fear of frivolous litigation is essential.

I am pleased that our associations were able to achieve a significant level of cooperation on this issue this year. We were able to provide leadership in some of the most difficult hours of the deliberation by our ability to communicate and cooperate. This does not mean that we were always in agreement; it does not even mean that we always won on every issue; but it does mean that we were able to effectively represent our collective memberships and find new strength in collective action.

Finally, I make one more point. During the regulatory era of the 1960s and the 1970s, hospitals and doctors developed an attitude of deference toward politics, government and the public. It seems that as long as funding was forthcoming and the health care delivery system continued to flourish, we were willing to compromise certain values of independence and self-determination. Now, it is clear that while our circled wagons have been successful in keeping intruders out of our encampment, in fact, the world is beginning to pass us by. Thus, it is essential that our organizations become proactive and exert our capacity for leadership.

In closing, I recall the words of Benjamin Franklin at the signing of the Declaration of Independence: "We must all hang together or assuredly we shall all hang separately." ☐



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Hypothalamic amenorrhea (HA) is a disorder which may follow strenuous physical exercise, excessive weight loss, periods of emotional stress, and use of oral contraceptives. Women with HA will be studied to determine if the oral administration of the opioid antagonist Naltrexone can correct the abnormal GnRH pulsatile secretion seen in these women. The aim is to reinitiate ovarian follicular development and restart ovulatory menstrual cycles. Patients will be women, age 18-35, with secondary amenorrhea of at least six months duration. Many will have a history of prior oral contraceptive use, strenuous exercise or history of weight loss. Subjects should be on no medications and within 10 percent of ideal body weight at the time of the study. There should be no evidence for specific etiologies of amenorrhea such as hyperprolactinemia, androgen (male hormone) excess, abnormal thyroid function, or systemic illness.

The study consists of an initial three day hospitalization at which time LH pulse frequency will be determined by frequent blood sampling for ten hour periods through an indwelling IV line during saline infusion, Naloxone infusion and oral Naltrexone administration—Naltrexone will then be given on a daily basis for three weeks. The patient will return on a weekly basis (for a ten hour period during the day) during the next four weeks for blood sampling and ovarian ultrasound exams. After acceptance into the study, hospitalization and laboratory test will be provided at no cost to the patient.

Contact persons for referrals: John C. Marshall, MD, PhD (313)936-4350 and Todd B. Nippoldt (313)936-5034, 3110 Taubman Center, Box 0368, Ann Arbor, Michigan 48109.

Hyperprolactinemia with amenorrhea: the effect of endogenous opioid antagonism on prolactin and gonadotropin secretion

Women with hyperprolactinemia have abnormal pulsatile secretion of GnRH. This may be responsible for the amenorrhea associated with elevated prolactin levels. Abnormal GnRH pulsatile secretion in other conditions has been corrected by administration of opioid antagonists. This study will determine if the abnormal GnRH secretion seen in women with hyperprolactinemia and amenorrhea can be corrected by opioid antagonism.

Women aged 18-35 with amenorrhea and moderate hyperprolatinemia (prolactin levels approximately 100-300 ng/ml) due to a pituitary microadenoma or of idiopathic etiology will be studied. There should be no history of pituitary surgery, radiation therapy, or use of psychotropic drugs such as Haldol. Patients will be off bromocriptine therapy temporarily at the time of the study.

The study will be done over a two day hospitalization, at which time LH pulse frequency will be determined by frequent blood sampling through an indwelling intravenous catheter during saline infusion, and during Naloxone infusion. After acceptance into the study, hospitalization and laboratory tests will be provided at no cost to the patient.

Contact persons for referrals; John C. Marshall, MD, PhD (313)936-4350 and Todd B. Nippoldt (313)936-5034, 3110 Taubman Center, Box 0368, Ann Arbor, Michigan 48109.

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Costs for the hospitalization and scanning are covered by NIH grants. Any surgery done would have to be covered by the patient's health care coverage plan.

Contact persons for referral: Allen S. Lichter, MD, Department of Radiation Therapy, University of Michigan Medical Center, Ann Arbor 48109 (313)936-4301; Max Wicha, MD, Division of Hematology and Oncology, U-M Medical Center, Ann Arbor 48109, (313)936-1831 or Richard L. Wahl, MD, Department of Internal Medicine, Division of Nuclear Medicine, U-M Medical Center, Ann Arbor 48109-0028 (313)936-5384.

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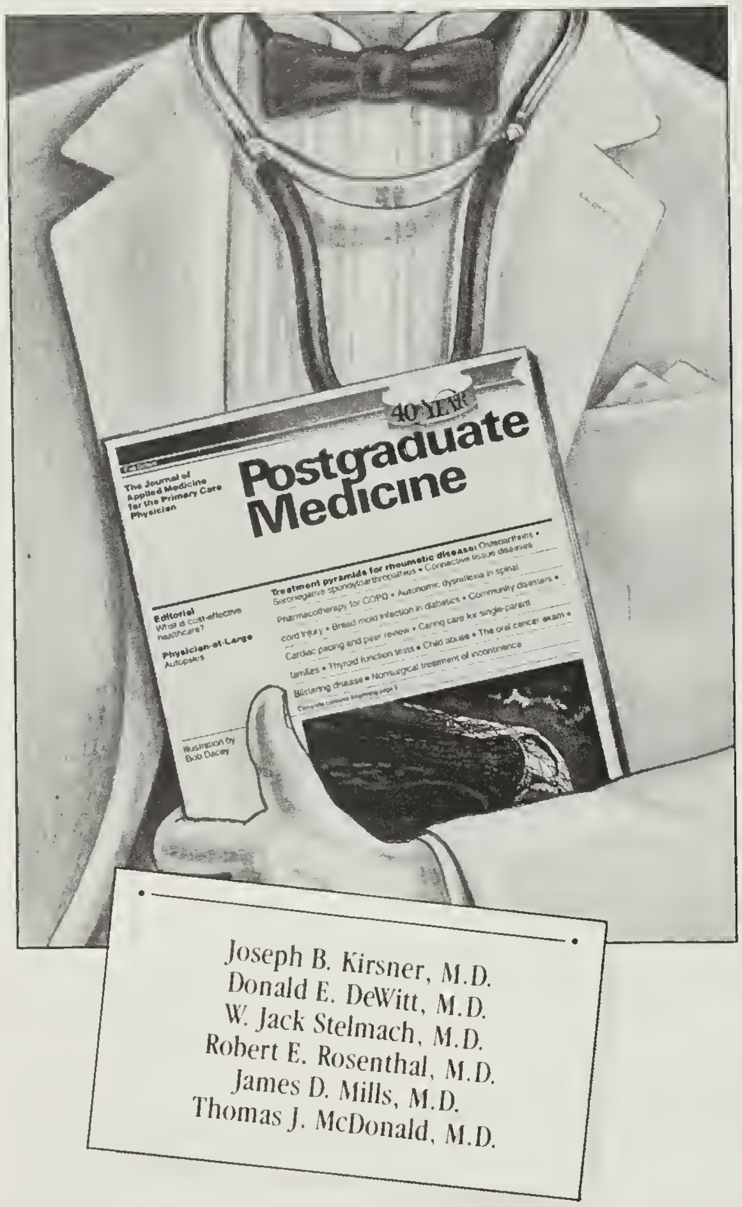

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Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: February 1-6, **Eleventh Annual Midwinter Family Practice Conference. Location:** Boyne Highlands Inn, Harbor Springs. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Towsley Center-Box 0201, University of Michigan Medical School, Ann Arbor 49109-0201 (313)763-1400. **Approved for:** 21.5 hours of Category 1 Credit.

Date: February 2-5, **Advanced Cardiac Life Support Provider Course (February 2 and 4 Recertification Course—8 Category I Credits—4 for BCLS and 4 for ACLS). Location:** Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Center—Staff and Patient Education Department. **Contact:** Claire A. Zieman, Staff and Patient Education, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-8320. **Approved for:** 25 Category I Credits (4 for BCLS and 21 for ACLS).

Date: February 4, **Psychotropic Drugs (Indications and Contra-indications and DMH Policy) and Diagnosis of Functional and Cortical Blindness (Screening Techniques & Current Technology). Location:** Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center, Michigan Department of Mental Health Bureau of Clinical and Medical Services. **Contact:** Charles L. Zeller, Jr., MD, SMAHEC, 4th Floor Stryker Center, 1521 Gull Road, Kalamazoo 49001 (616)388-7877. **Approved for:** 6 hours of Category I Credit.

Date: February 11, **Update in Diabetes Management. Location:** Fairlane Manor, Dearborn. **Sponsor:** Wayne State University of Medicine. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, 4201 St. Antoine, 4-H, Detroit 48201 (313)577-1180. **Approved for:** 7 hours of Category I Credit.

Date: March 4, **Stroke: A Multidisciplinary Approach. Location:** Kalamazoo Hilton Inn. **Sponsor:** Borgess Medical Center neurophysiology Department and Southwestern Michigan Area Health Education Center. **Contact:** Bill Daam, Neurophysiology Department, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-4895. **Approved for:** 5.75 hours of Category I Credit.

Date: March 12-14, **Advanced Cardiac Life Support (Provider & Recertification) Course. Location:** Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Life Support Services and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. **Approved for:** Category 1 Credit: 20 credits for ACLS and 6 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

Date: March 12-17, **Ophthalmology: Basic and Clinical Review Course. Location:** Hotel Pontchartrain, Detroit. **Sponsor:** Kresge Eye Institute of Wayne State University School of Medicine. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, 4H University Health Center, 4201 St. Antoine, Detroit 48201 (313)577-1180. **Approved for:** 42 hours of Category 1 Credit.

Date: March 13-14, **Annual Postgraduate Course in Obstetrics and Gynecology: Challenges and Changes of the 1980s. Location:** Towsley Center, University of Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Office of Continuing Medical Education, The University of Michigan, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 12.3 hours of Category I Credit.

Date: March 18, **Dermatology. Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital Continuing Medical Education Committee. **Contact:** Carol Mastroianni, Program Coordinator, CME, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: March 24-28, **Family Practice—Eleventh Annual Spring Refresher and Board Examination Review. Location:** Towsley Center, University of Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Georgia Barton, Office of Continuing Medical Education, University of Michigan Medical School, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 33.75 hours of Category I Credit.

Date: March 25-26, **Michigan Conference on Maternal and Perinatal Health. Location:** Hyatt Regency, Dearborn. **Sponsor:** MSMS. **Contact:** Sherry Fent, 120 W. Saginaw, East Lansing 48823 (517)3371351. **Approved for:** 13 hours of Category I Credit.

Date: April 1, **Pulmonary Rehabilitation Symposium. Location:** Fetzer Center, Western Michigan University, Kalamazoo. **Sponsor:** Pulmonary Services, Borgess Medical Center and Southwestern Michigan Area Health Education Center. **Contact:** Judy Smith, Pulmonary Services, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-4875. **Approved for:** 5 hours of Category I Credit.

Date: April 3-5, **Tutorial on Level I Myofascial Release Technique. Location:** Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. Contact: Sandy Kilbourn, MA, Director of Continuing Medical Education, MSU College of Osteopathic Medicine, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. Approved for: 24 hours of Category I Credit.

Date: April 6-9, Advanced Cardiac Life Support Provider Course. (April 6 and 8 Recertification Course—8 Category I Credits—4 for BCLS and 4 for ACLS). Location: Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Center—Staff and Patient Education Department. **Contact:** Claire A. Zieman, Staff and Patient Education, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-8320. **Approved for:** 25 Credits, 4 for BCLS and 21 for ACLS.

Date: April 10, Flexible Sigmoidoscopy Conference. Location: Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Charles L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 5.5 hours of Category I Credit.

Date: May 14, Sexually Transmitted Diseases—1987. Location: Fetzer Business Development Center, Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Charles L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 6 hours of Category I Credit.

Date: May 15-17, Advanced Cardiac Life Support (Provider & Recertification) Course. Location: Gilmore Center of Health Education Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Life Support Services and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. **Approved for:** Category I Credit: 20 credits for ACLS and 6 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

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MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

January 21 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

February 20-22 — AMA National Leadership Conference, Chicago, contact: Michelle Zaba (312)645-4430.

February 25-27 — AMA Medical Profession: Eduring Values and New Challenges, Los Angeles, contact: Pat Clark (312)645-4497.

March 18 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

March 21 — MSMS Hospital Medical Staff Section Annual Meeting, Hyatt Regency, Dearborn, contact: Thomas White, MSMS Headquarters, (517)337-1351.

April 24-25 — MSMS House of Delegates, Amway Grand Plaza, Grand Rapids, contact: William Madigan (517)337-1351.

May 7-8 — AMA National Conference on AIDS, Marriott Hotel, Chicago, contact: Pat Clark, AMA (312)645-4497.

July 16-19 — MSMS Board of Directors Midsummer Meeting, Deer Lake, Boyne Mountain, contact: William Madigan (517)337-1351.

September 23 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

November 18 — MSMS Board of Directors Meeting, MSMS Headquarters, contact: William Madigan (517)337-1351.

OTHER MEETINGS

January 14 — Michigan Allergy Society, Program: Animal Dander Allergy, Dearborn Inn, contact: Viola Heins, MSMS Headquarters (517)337-1351.

February 4-5 — Michigan Health Officers Association, Directors Conference, Amway Grand Plaza Hotel, Grand Rapids, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313) 243-7144.

March 5 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, Lansing, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313) 243-7144.

April 3 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313)243-7144.

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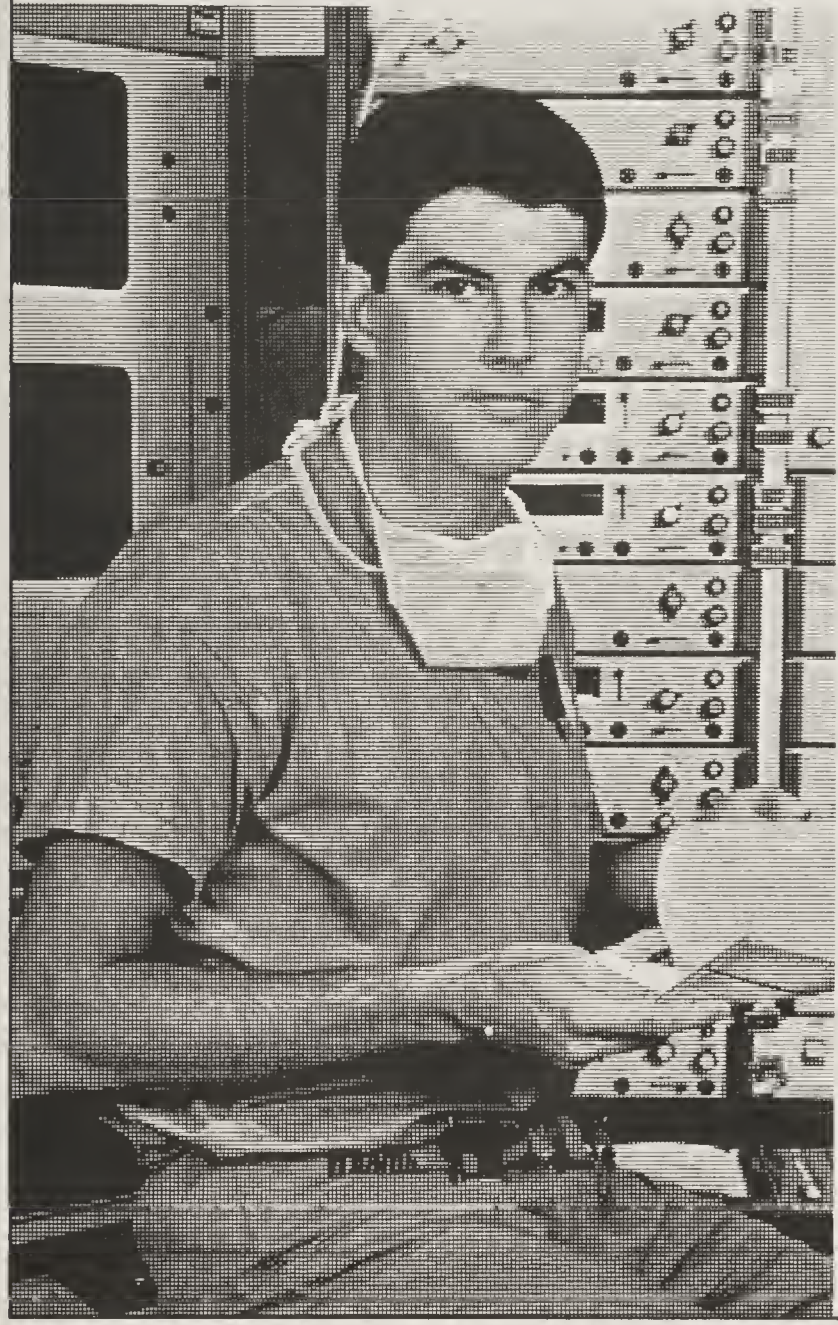

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I'm from the government and I'm here to help you

An old story states that the three biggest lies ever told are:

"The check is in the mail."

"I'll respect you in the morning," and

"I'm from the government and I'm here to help you!"

All of my medical/political life has been devoted to trying to get all of my colleagues' attention as to what the government is doing to (for) us, and trying to get you to help redirect the government. In this short column I want to direct your attention to two recent events. I won't dwell on what Prospective Payment and DRGs have done to you and your patients or the effect the PRO has on you. You don't want to hear that if you have three early discharges in one year, you can have criminal sanctions placed on you before any appeal. I won't enumerate the many laws that have a profound effect on your life or the many bills that are being introduced that could affect you greatly. Rather, I describe two recent events:

In the mail recently I received a letter from Blue Cross Blue Shield outlining the recent changes in reimbursement under Medicare. After I read the letter twice and still didn't understand it, I read it to my wife who just laughed. I then asked my clinic administrator (who deals in this every day) to explain it to me. He said that he had been through it three times, had our insurance person review it, and still didn't understand it so he is going to Chicago for a HCFA teleconference where, hopefully, someone can explain it to him.

Thomas R. Berglund, MD

In essence, the government promised everyone over 65 the right to medical care in 1965. We told them then it would be many times more expensive than their estimates and now, as predicted, the system is going broke. In order to reduce costs they implement the above-mentioned reimbursement system to save money and make it so complicated that most do not understand it. Finally, if you do not comply, you can be prosecuted. They really are trying to help us!

The other recent event was our Michigan legislature's refusal to fund Medicaid. By some strange logic they refused to pay for all poor people's medical care over an ideological dispute over abortion. Most of us who have a small proportion of Medicaid patients were glad to weather the storm, but many physicians in inner-city Detroit and other areas, as well as some hospitals, had severe cash flow problems. The fact that they sped home quickly without taking any action on this issue should tell you that our own Michigan government is really trying to help us!

Over the past 20 years I have seen many laws passed, some good and some bad, which affect us. Dedicated physicians have given a great deal of time trying to affect the legislative process on your behalf. As we begin this new year, I ask each of you to make several resolutions. Namely, to pay attention to MSMS and AMA legislative alerts, to contact your elected officials both (state and federal) when proposed laws affect us, and to become involved in the political process so you will be ready for the 1988 elections.

The more things change, the more they stay the same. The new version of that old story states that the four biggest lies ever told are:

"I've always worn cowboy boots."

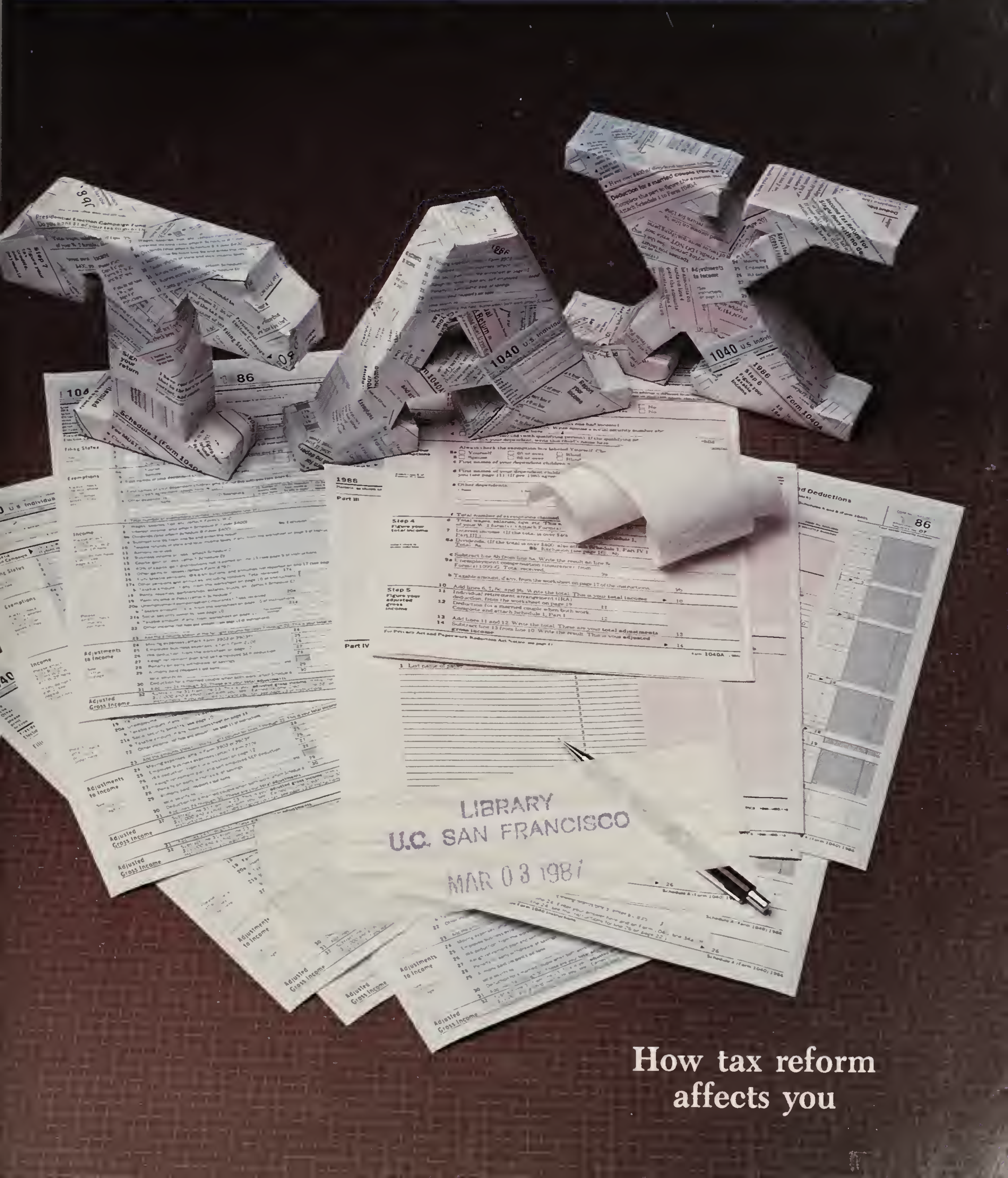
"It's only a cold sore."

"Of course it's IBM compatible," and

"I'm from the government and I'm here to help you!"□

MICHIGAN MEDICINE

FEBRUARY 1987 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY VOL. 86, NO. 2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MEDICINE
FEBRUARY 1987 VOL. 86, NO. 2

Special Report

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In next month's issue of *Michigan Medicine:* Highlights of American Medical Association goals, programs and benefits.

Cover photo by Kim Kauffman.

AMA meeting was an eye-opener

By Marguerite Shearer, MD

Marguerite Shearer, MD

Doctor Shearer, Dexter family physician, is a member, MSMS Board of Directors and MSMS Committee on Publications.

It was my privilege to attend the American Medical Association 13th Annual State Health Legislation Meeting in Orlando, Florida, January 4-7, 1987. My attendance was sponsored by MSMS.

The topics discussed were wide-ranging—from acceptance of Medicare assignment as a condition of licensure, to tort reform, the AMA Adolescent Health Initiative, AIDS and public education, physician manpower, long-term care insurance, quackery, legislative initiatives and a smoke-free society by 2000.

John Coury, MD, AMA president, opened the meeting and Kevin Kelly, MSMS manager of government relations, participated on a panel discussion.

Mandatory assignment was a major topic. There was concern that it would increase utilization decrease access and produce two-tiered medical delivery system. It seems to me that som type of means testing would b more equitable; i.e. on the basi of the previous year's W-2 statement. This was not discussed however.

We heard from a Massachusetts attorney representing th Greater Boston Elderly Lega Service who supported mandatory assignment as a contingen to medical licensure (Massachusetts currently requires acceptance of assignment in order to b licensed in the state); from legislative representative of th American Association of Retire Persons who expressed concern about the advisability of such plan; and from the AMA attorney.

Tort reform strategy was dis

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cussed by a Maryland MD who became a fulltime lobbyist for the Maryland physicians—he advised that high visibility of physicians ("front row") at all meetings, hearings and backroom discussions was crucial. We heard recommendations that we be armed with local statistics, be ever ready to respond and to be sure to emphasize *health care* problems, not *doctors'* problems. Ability, availability and affability were felt to be important cornerstones to a successful campaign for reform.

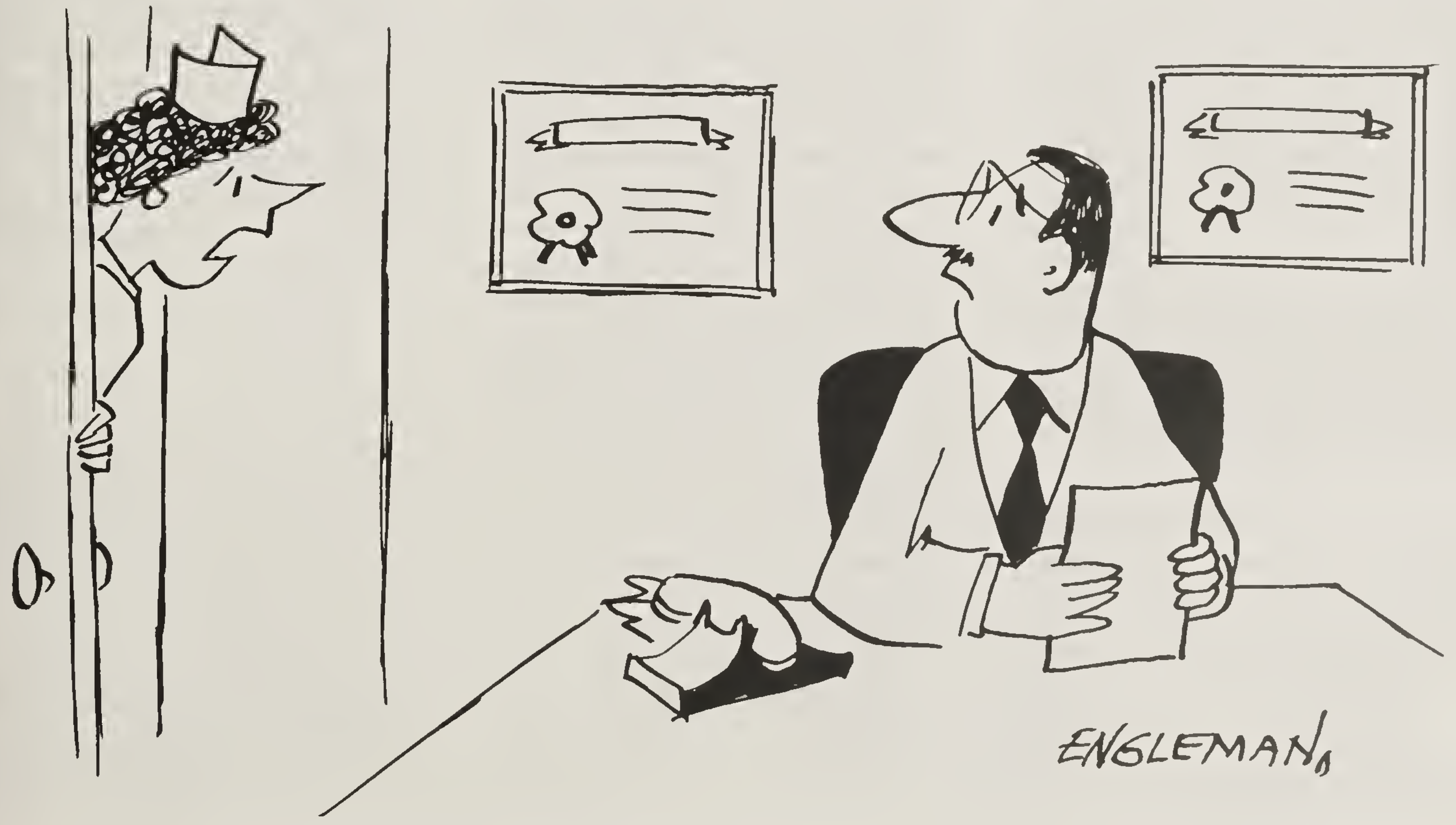
A sobering talk

James Sammons, MD, AMA executive vice president, gave a most sobering, thought-provoking talk about the health status of adolescents in this country. The statistical data represented was truly awesome; we will be hearing more about AMA initiatives to combat teenage pregnancy, drug abuse, child abuse and venereal disease, and to improve the physical and mental health of this country's youth.

William R. Hendee, PhD, AMA vice president for science and technology, stated that the AMA is committed to being certain that MDs have the most up-to-date information on AIDS. Regular articles in JAMA are planned, as well as monographs on AIDS. He felt strongly that physicians need to be in the forefront of the educational process about this disease. He urges us not only to become informed, but also to give our time to civic, student and parent groups. We must enhance their understanding. He stressed that to date, prevention is the only "treatment."

The final speakers addressed legislative strategies toward achieving a smoke-free society by the year 2000 and the requirements to mount a legislative initiative. Recently San Francisco passed a clean indoor air law; the speaker discussed the strenuous efforts of the tobacco industry to thwart that effort. He advised us that local efforts were most effective.

I came home better informed and with a widened horizontal view. ☐



"More than half of the patients in the waiting room have attorneys with them!"

Effects of the 1986 Tax Reform Act on your personal tax return

By Andrew M. Savel and Harriet Orley

The Tax Reform Act will affect all taxpayers in some respect. This article will focus on changes in the tax laws as they affect an individual's return.

The tax rates

Beginning with 1987, there will be changes in traditional tax rates. Basically, there will be two tax rates—15 percent for those filing singly up to a taxable income of $17,850; and those filing jointly up to an income of $29,750. Above those figures, you are placed in a 28 percent bracket. In addition, on a single filing of $43,150 and $71,900 for joint, you will pay an additional five percent surcharge until the benefit from the lower tax bracket is paid back (at the $89,560 level for single individuals and $149,250 for joint filers). This surcharge then will continue to be applied until the benefit of all exemptions is repaid.

On October 22, 1986, President Reagan signed the Tax Reform Act of 1986. This act is by far the most radical change in the tax laws during this decade. Many of the deductions, loopholes and shelters have been eliminated.

The new tax rates do not take full effect until 1988. For 1987, the old rates are blended into the new rates. This is referred to as a transitional rate.

The dollar amounts on personal exemptions will be increased beginning with the 1987 tax year. Personal exemptions in 1986 are worth $1,080. In 1987 the personal exemption will be $1,900; $1,950 in 1988; $2,000 in 1989; and from 1990 on, it will be adjusted for inflation. The current extra exemptions for the elderly and blind will be eliminated and the standard deduction for this category of taxpayer will be increased. An individual who can be claimed as a dependent will lose his own exemption. The standard deduction for those who do not itemize will be increased from the current $2,570 (single) and $3,800 (joint) to $3,000 (single) and $5,000 (joint) in 1988.

Adjustments to gross income

The traditional adjustments to gross income have also been modified under the Tax Reform Act. The deduction available to working spouses filing a joint return is repealed. This deduction was traditionally meant to alleviate the marriage penalty inherent in the tax tables. Contributions to Individual Retirement Accounts may no longer be an adjustment to your gross income. The deduction may not be available if you or your spouse are covered by a qualified plan and adjusted gross income exceeds $25,000 (single) or $40,000 (joint). This is applicable even if the participant is not vested or no contribution is made to the plan that year. Non-deductible contributions may still be made, to previous levels, and will accumulate tax free.

Itemized deductions

Certain itemized deductions have been eliminated or altered Once you compute your adjusted gross income you may take a medical deduction if such costs are greater than 7.5 percent of the adjusted gross income. A deduction for charitable contributions of non-itemizers has been eliminated. Local sales tax is no

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1987 transitional (blended) rates

	Single	Joint	H of H
11 percent	0-$1,800	0-$3,000	0-$2,500
15 percent	-$16,800	-$28,000	-$23,000
28 percent	-$27,000	-$45,000	-$38,000
35 percent	-$54,000	-$90,000	-$80,000
38.5 percent	excess	excess	excess

onger deductible. Real and peronal property taxes such as the Michigan intangibles has been reained.

Only certain types of interest xpense will be deductible in the upcoming years. Consumer or ersonal interest expense has been liminated. This includes such tems as interest on credit cards ınd automobile loans. Residenial mortgage interest on your irst two residences is deductible o the extent of interest attributıble to loans up to the cost plus mprovements.

If there is excess interest, it is leductible if used for education r medical purposes only. Investnent interest expense is deductble only to the extent of net inestment income. This pertains to ortfolio interest such as stocks, onds, etc. There are transitional ules applicable to this category. Disallowed investment interest luring the phase-in period may e carried forward and used in a ubsequent year against net inestment income.

Miscellaneous deductions

Traditionally, miscellaneous temized deductions were fully leductible. Beginning in 1987, hese deductions must exceed two ercent of adjusted gross income. The deductions include amounts aid for such items as business ubscriptions, safe deposit boxes, ax preparation, etc. There are a ew exceptions to this two percent rule so consultation with a tax planner is advisable.

Credits and income

The investment tax credit has been repealed retroactively for assets purchased after December 31, 1985. Political contribution credit has been repealed. Dividend exclusion and the 60 percent long-term capital gain deduction has been repealed. Income averaging will no longer be available after 1986 and estimated taxes must equal at least 90 percent of total tax liability (currently, 80 percent).

Tax shelters

Passive income (loss) is defined as income (loss) from business activity in which the taxpayer does not materially participate. Tax shelter investments generally fall into this category. Passive losses are deductible only against passive income. Portfolio income (income earned from stocks, bonds, etc.) is not considered passive income for these purposes. These losses will be gradually phased out. Unused losses and credits can be carried forward and used against future passive income or allowed in full upon sale.

Rental activity is also passive income. However, losses in excess of passive income are deductible only if you actively participate in managing the property. The limit on this deduction is $25,000. Once you reach the $100,000 income level, the rental loss allowance begins phasing out. The transitional rules also apply to this item.

Unearned income of minors

Certain income shifting devices will no longer be available. Income from Clifford and spousal remainder trusts as established after March 1, 1986 will be taxed to the grantor. Pre-March 1, 1986 transfers will be taxed to the beneficiary, subject to the new rules for minors. If the child is under 14 years of age, the first $500 is sheltered by the child's standard deduction. The next $500 is taxed at the child's rate (presumably 15 percent) and any amount after the first $1,000 will be taxed at the parent's marginal rate.

Alternative minimum tax (AMT)

The current alternative minimum tax will be applicable to a

Continued on next page

TAX RETURN/Continued

greater number of taxpayers since items which are included in the definition of alternative minimum taxable income have been increased. To the extent that losses from passive investments (e.g. tax shelters) have been used in computing taxable income, such losses must be included in determining alternative minimum taxable income. Income from certain municipal bonds issued after August 7, 1986, even though exempt from regular income tax, will be includable for AMT purposes. The unrealized appreciation on property contributed to charity will also be considered an AMT item.

Summary

The Tax Reform Act of 1986 will have great impact upon tax planning strategies of the future. Traditional tax shelters, deductions and tax rates all reflect some type of change. Keep in min that effective tax planning requires consideration of curren and future tax laws, your ta bracket currently and for futur tax years, as well as how thes items relate to your personal investment and expenditure preferences. ☐

Tax rates

Rate structure changes are effective for tax years that end after July 1, 1987, based on the following schedule

Taxable income	Prior to 7-1-87	After 6-30-87
$ 25,000 or less	15 percent	15 percent
25,001- 50,000	18 percent	15 percent
50,001- 75,000	30 percent	25 percent
75,001-100,000	40 percent	34 percent
100,001-335,000	46 percent	39 percent
over $335,000	46 percent	34 percent

Investing after tax reform

By Richard L. Greene

Taxation is one of the vector forces which shape the economy. Much has been speculated on how the Tax Reform Act (TRA) will affect the US economy in 1987 and beyond. The experts can't seem to agree on a forecast —the only thing certain is uncertainty.

Tax reform is fundamentally better for the economy in theory, what is worrisome is the abruptness of the change. Just as a diabetic might face a crisis if radical changes in diet or medication were introduced too quickly, so too there will be sectors of the US economy that will be radically affected by the new law. There could be "shocks" to the system that reverberate throughout the whole economy.

Furthermore, tax reform is not the only major change that has taken place in the last year or so. On the positive side, we have experienced precipitous drops in oil prices, interest rates, and the dollar relative to the major Western currencies. Gold is up over 30 percent, the stock market reached new highs and inflation remained low. The bad news is that our deficit continues to grow, banks and farms are failing in record numbers, and South Africa is teetering. What this all adds up to is more potential for volatility in the various markets.

It's time to take off the rose-colored glasses and get out your binoculars. The Tax Reform Act of 1986 will present American taxpayers with the most abrupt change in their taxation in history.

Supposedly the Chinese character for the word "crisis" is a composite of the characters of the words "danger" and "opportunity." Due to TRA '86 and the other changes mentioned, 1987 will likely create crisis situations in the economy. Tactically it is prudent to first defend against the dangers before capitalizing on the opportunities.

Three things that don't change

The first and primary defense against making bad investments in any economic climate is to "know thyself." Our most basic financial goals don't really change. Most people have five major goals:

1. Positive cash flow (i.e. make more than they spend);
2. Security in the face of catastrophes (such as death, disability, lawsuits, etc. This usually boils down to adequate insurance.);
3. Educational funds to put children through school;
4. Retirement funds to be able to retire at a desired age and standard of living;
5. Guilt free money (If you know you're doing enough to take care of the first four goals this is what's left over.)

These goals should form the basis of a written financial plan that tells you where you are now, where you want to be, by when, and how to get there. Such a plan gives one perspective when confronted with an investment decision. You don't necessarily need a costly 80-page computerized plan with 70 pages of boilerplate and your net worth shown in a pie chart, bar chart and line graph. An eight page white paper is sometimes much more readable and useful if it follows what we call the FOPPSI logical progression: Facts, Objectives, Projection, Problems, Solutions, Implementation.

The second thing that doesn't change is time. You know how much time you need to reach your major goals and how much time is available to spend maintaining and researching investments. For the typical physician working 50 + hours per week and involved in family and community activities, there isn't that much time. For that reason most physicians should look to financial planners to help manage their money and lean toward mutual funds, unit trusts, and limited partnerships as investment vehicles. For those with more than $200,000 to invest, another alternative is to employ a "money manager." For a typical

Continued on next page

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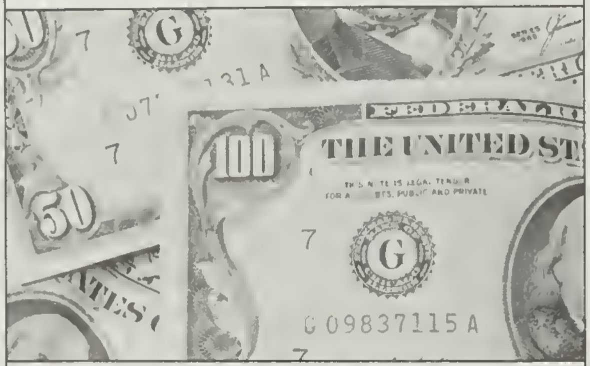
yearly fee of one or two percent of assets, money managers can devise a portfolio to match your objectives and risk tolerance.

The third thing that doesn't change is the dependable investment, i.e. it guarantees principal and has a more or less predictable interest rate. These include money market accounts, banks and S&L accounts, short term US Treasuries, commercial paper, bankers acceptances, certain types of life insurance and annuities. Many people are getting frustrated with the current low interest rates. You look at the six percent offered on one year CDs by your local bank and long for the good old days when money market accounts paid 15 percent. But what is important to remember is that its the "real" interest rate adjusted for inflation and taxes that counts. The money market fund which earned 15 percent for the 50 percent bracket taxpayer in 1979 netted 7.5 percent after taxes—subtract the inflation rate of 13.5 percent and we see a five percent loss of purchasing power. The six percent CD after tax reform will net four percent after tax minus the inflation rate of two percent, that is a "real" gain of two percent. Historically, the real interest rate has averaged one to two percent per year. By that measuring stick, municipal bonds, annuities, and certain types of life insurance offering high tax sheltered yields are splendid investments.

Be careful of bonds

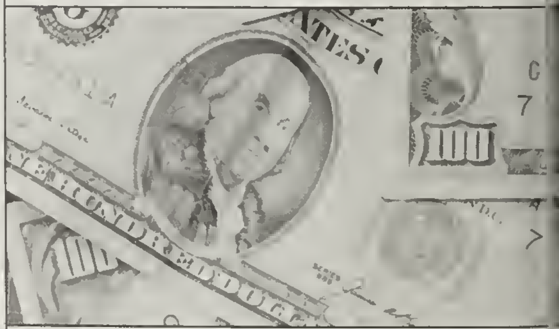
The frustration with low interest rates has many people looking at the bond markets for higher yields. Corporate and government bond funds advertise yields in excess of 10-11 percent. If our economy stabilizes and interest rates stay low these will prove to be great investments. However, many of those rushing into the bond market are not aware of the inverse relationship between interest rates and the price of a bond. When interest rates rise the selling price of my bond goes down. A 10-year Treasury with current coupon will lose seven percent of its value for every one percent rise in interest rates; a 30 year Treasury would lose 11 percent. The opposite is also true, if interest rates go down, the selling price of a bond goes up. Many of the spectacular yields being boasted by bond funds were obtained because of appreciation due to the precipitous drop in interest rates in the last year.



Ask yourself these two questions: Do you really think interest rates can drop very much lower? Is there a reasonable possibility that in the next three to five years we could be looking a a significant rise in interest rates If your answers are "no" to th first and "yes" to the second question, then approach the bond market with some healthy fea and have a plan in place to tak appropriate action should interest rates begin to climb. If yo don't, you may end up like many investors in the last decade whos bonds purchased in the early '70 lost over half their market valu by the late '70s when interes rates had climbed to doubl digits.

Stocks for growth

If ignorance of how the bond market works is the first dange to defend against, the second i an over-optimistic attitude toward the stock market. Since 1982 investors have enjoyed the greatest bull market in history.



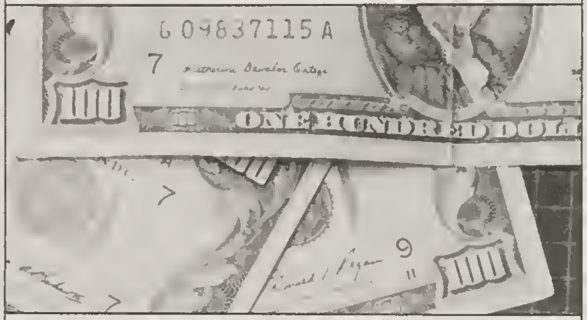
You hear friends bragging about the killing they made in the stock market, or maybe you read *Money* magazine and note that even mediocre stock mutual funds have been averaging over 20 percent per year the last five years. It's easy to extrapolate these present rates of returns out or 10 more years and figure that with a small investment now you would be able to fund a museum in 1996. Unfortunately, markets don't climb forever, there tends o be a cyclical nature to things. Selling stock when the Dow Jones ndustrial Average (DJIA) was in he 800s in 1981 was like pulling eeth; it is amazing that so many people feel that there is more opportunity in the market now that he DJIA has risen to over 1,900!

There are a lot of great reasons the bull can keep running and the Dow could break 3,000 by the year 1990. Personally I'm still optimistic about the US stock market and think it's a good investment, but there also are many reasons the economy might stall and the inevitable bear market could make an early appearance.

A down year in the stock market can be devastating. If you buy a stock at $100 a share it goes up 50 percent the first year, down 50 percent the second, have you broken even? No: you have lost 25 percent of your investment ($100 up 50 percent is then $150—down 50 percent is then $75!). For this reason I'd diversify my stocks and look for performers that would do better in a bear market. Perhaps the best places to acquire this kind of portfolio are in stock mutual funds that have a long track record showing outstanding performance in the bad times as well as the good. Some good places to find these types of funds, are in the Forbes magazine "Mutual Fund Honor Roll" and in Money Magazine's "Fund Watch" section under "All Weather" funds.

The big loser

Perhaps the single sector of the economy that has been hardest hit by the tax reform act is real estate, especially real estate limited partnerships (RELPs). Congress aimed a rocket launcher at the traditional real estate tax shelter and pushed the button. Most of the "deep shelter" RELPs will do well just to survive. Many are struggling not only because of tax reform but also due to regional overbuilding (e.g. Phoenix) and/or economic distress (e.g. Houston). But in all crises there is opportunity and many unlimited partnerships that are foregoing leverage and raising money for "all-cash" purchases will be able to buy or develop real estate at bargain prices. "All-cash" RELPs will typically start out with a moderate yield which should rise yearly as rents are increased. After several years sale of properties could bring handsome capital gains. Because they are longer term and not very liquid this kind of RELP is often used in qualified retirement plans. For those individuals who own deep shelters (where the passive losses are being phased out for ordinary income) a personally held "all-cash" RELP provides passive income which can be 100 percent sheltered by passive losses generated by the shelter. One caution, make sure the general pattern is financially sound and not in dire straits due to all the deep shelters they might have promoted in past years.



The big winners

If real estate was the big loser of the TRA '86, life insurance was a big winner. The insurance companies have become co-competitors with banks and brokerage houses for your investment dollar. Their big victory came in that the internal build up of cash values within policies was able to retain its tax-deferred status. Now the standard universal life insurance policy emerges as one of the best places to store your longer term fixed interest money. In addition, a plethora of new types of policies emphasizing investment return and delivering it in tax-favored fashion will hit the market this year.

One battle the insurance lobby lost was in the loss of interest deduction for policy loans. If you have a "minimum deposit" plan where premiums are borrowed from existing cash value it probably needs to be reevaluated. Most simply won't fly without the

Continued on next page

Pension plans remain the ultimate tax shelters

By Julius H. Giarmarco

The following is a summary of the major elements of the Act which affect pension and profit sharing plans and their participants.

Section 401(k) plans. Beginning in 1987, the annual maximum pre-tax salary deferral to a 401(k) plan is reduced from the lesser of 25 percent of compensation or $30,000 to the lesser of 25 percent of compensation or $7,000. The $7,000 cap will be indexed for inflation. The average deferrals of the "highly compensated" group of employees is further limited by the average deferrals of all other employees based upon the following table:

All others	Highly compensated
0% to 2% × 2 =	0% to 4%
2% to 8% + 2% =	4% to 10%
8% to 12% × 1.25 =	10% to 15%

While the central focus of the Tax Reform Act of 1986 is the dramatic lowering of marginal tax rates, the new law also makes significant changes in the pension area.

Excess contributions may be returned without incurring the 10 percent early withdrawal excise tax.

Tax deferred 403(b) annuities. The annual maximum pre-tax salary deferral to a tax deferred annuity is limited to the greater of $9,500 or the cap or elective deferrals to a 401(k) plan

Contribution and benefit limits. The Act retains the limit on annual benefits from a defined benefit plan, which is the lesser of 100 percent of compensation or $90,000. However, after 1986, the $90,000 limit must be actuarially reduced (with no floor) for pensions that begin before the Social Security retirement age (currently age 65). Under prior law

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INVESTING/Continued

tax savings from the interest deduction.

In summary, approach the next year with caution. There are plenty of good investment opportunities but keep your guard up.

Here are our investment recommendations for the full-time physician with limited amount of time to monitor a portfolio:

1. Mutual funds: Stock funds that have shown steady, measured growth over a long period of time and have done especially well in down markets.
2. Municipal bond funds and unit trusts: Despite the risks of discounting, net after-tax rates of return relative to the market have never been higher.
3. "All-cash" real estate limited partnerships: Limited partnerships with all cash will be able to pick up properties for a song in the coming tax shelter bloodbath.
4. Cash value life insurance: One of the few places that your money can receive high tax-deferred interest and still be withdrawn on a FIFO basis without penalty.
5. Higher interest brokered CDs: Brokered CDs under $100,000 with no more than a one year maturity offer you a guaranteed principal and interest investment with an extra one or two percent over your local rate CDs. ☐

the reduced maximum benefit was $90,000 at age 62 and $75,000 at age 55. Under the Act, the maximum benefit would be $72,000 at age 62 and only $37,404 at age 55. An important exception is provided for benefits already accrued. The defined contribution limit of the lesser of 25 percent of compensation or $30,000 will remain. The $90,000 limit will be indexed for inflation after 1987, but the $30,000 limit is frozen until the defined benefit limit reaches $120,000.

Plan coverage. The Act imposes stricter coverage rules for all qualified plans. After 1988 a plan must meet one of three coverage tests:

1. Percentage test—The plan must cover 70 percent of all "non-highly compensated" employees (as opposed to just 70 percent of "all employees" under current law); or
2. Ratio test—The percentage of "non-highly compensated" employees covered by the plan must be at least 70 percent of the percentage of "highly compensated" employees covered; or
3. Average benefits test—The prior law classification test must be met and the average benefit for "non-highly compensated" employees must be at least 70 percent of the average benefit for "highly compensated" employees.

Minimum participation. Beginning after 1988, the use of separate, but "comparable," plans for owners versus all other employees is severely restricted by the Act. Under the new law each plan must benefit at least 40 percent of all employees. This rule will require many PCs to merge or terminate such plans.

Vesting. The vesting of non-top heavy plans must be either 100 percent after five years of service, or seven-year graded vesting (three years/20 percent; four years/40 percent; five years/60 percent; six years/80 percent; and seven years/100 percent), for plan years starting after 1988. Moreover, the 100 percent vesting rule after three years of service under current law has been replaced with a rule which provides for two years of eligibility to participate with 100 percent vesting after two years of service. For top heavy plans the current rules are retained except that the three year/100 percent vesting rule will be replaced by the two year/100 percent vesting rule described above.

Integration with Social Security. Under current law, a top heavy defined contribution plan can provide a minimum contribution of three percent below the integration level and 8.7 percent (three percent plus the 5.7 percent OASDI portion of FICA) above the integration level. Similarly, a top heavy defined benefit plan can provide a minimum benefit of 20 percent of compensation below the integration level and 57.5 percent of compensation (20 percent plus the 37.5 percent deemed Social Security benefit) above the integration level.

However, the Act significantly reduces the advantage to the higher paid employees of integrating a pension or profit sharing plan with social security. Be-

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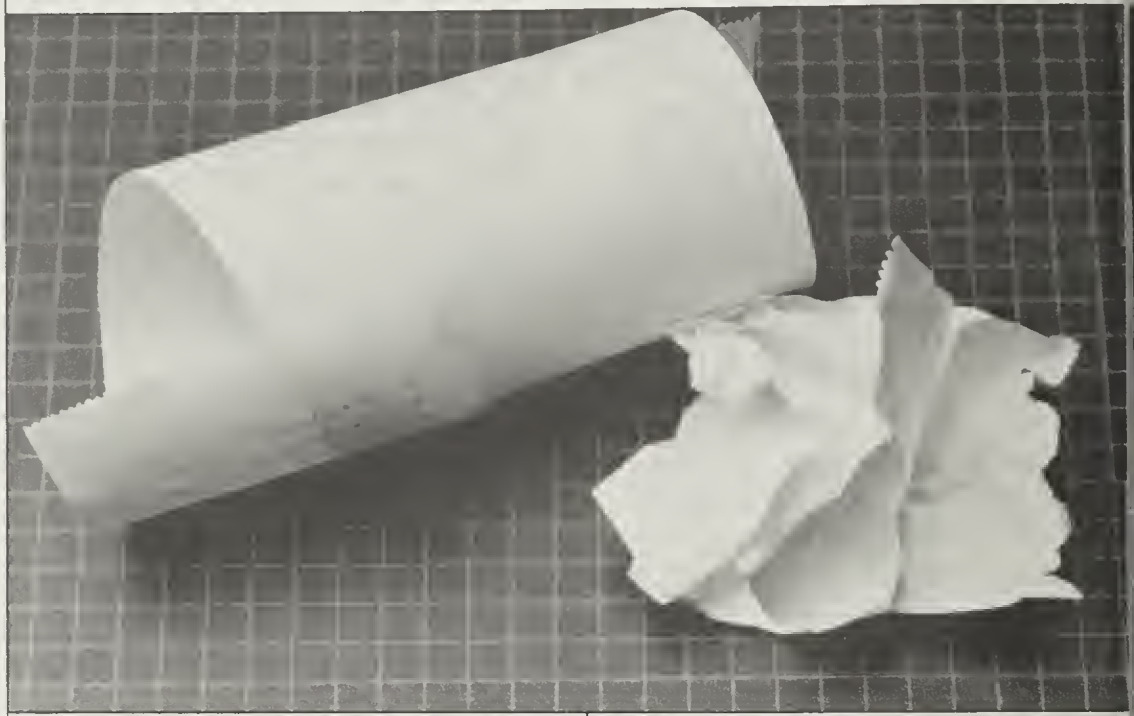
PENSION/Continued

ginning in 1989, the benefit/contribution rate below the integration level cannot be less than 50 percent of the benefit/contribution rate above the integration level.

Minimum distributions. Beginning in 1989, distributions under qualified plans must commence no later than April 1 of the calendar year following the calendar year in which the participant (not just five percent owners as under current law) attains age 70½, without regard to the actual date of retirement. Non-five percent owners who attain age 70½ by January 1, 1988, and participants who made a designation under Tax Equity and Fiscal Responsibility Act of 1982, can continue to defer distribution until their actual retirement date. The participant is subject to a 50 percent excise tax on the amount which is not distributed.

Early withdrawals. Beginning in 1987, the Act applies a 10 percent excise tax to withdrawals from qualified plans made before death, disability or attainment of age 59½. Exceptions to this rule are available for:

1. Distributions in the form of an annuity payable over the life of the participant or the joint life of the participant and the participant's beneficiary;
2. Distributions to a participant who has attained age 55, separated from service, and who qualifies for early retirement under the plan;



3. Distributions used to pay medical expenses deductible for income tax purposes;
4. Payments to an alternate payee pursuant to a qualified domestic relations order; and
5. Cashout distributions of $3,500 or less.

Under current law the 10 percent excise tax on early withdrawals applied only to five percent owners.

Excess retirement distributions. Beginning in 1986, a 15 percent excise tax is imposed on an individual's aggregate distributions in excess of $112,500 received in a year from all qualified plans, tax deferred annuities and IRAs. The aggregate distribution limit for lump-sum distributions is five times the otherwise applicable aggregate annual distribution limit for the year. The $112,500 limit is indexed for inflation. The new law does not apply to benefits accrued prior to August 1, 1986. It also does not apply to distributions with respect to a deceased participant and distributions not includible in income by reason of a rollover contribution.

Ten year averaging. Beginning in 1987, 10-year income averaging will be replaced by a one-time election of five-year averaging for a lump-sum distribution received after attainment of age 59½. Attainment of age 59½ is not required under present law for all lump-sum distributions. Under a transition rule, individuals age 50 as of January 1, 1986, may elect (one time) 10-year averaging at 1986 rates or five-year averaging at the new rates, before or after attaining age 59½. In spite of the lower tax rates under the Act, the 10-year averaging election will be more advantageous than the five-year averaging option, unless the lump-sum distribution exceeds $420,000.

Plan loans. For loan proceeds received after 1986, the Act (1) limits the ability of participants to maintain permanent loan balances by reducing the $50,000 limit on plan loans by the participant's highest loan balance during the prior 12 months; (2) Limits the exception to the five year repayment period to loans applied to the purchase (but not improvement) of the participant's (but not a family member's) principal residence; (3) denies the interest deduction for loans to key employees; and (4) requires all plan loans to be amortized in level payments not less frequently than quarterly over the term of the loan.

Deductions and funding. Beginning in 1987, the Act eliminates the ability to make up for profit sharing contributions of less than 15 percent in a future year by repealing the credit-limit carry forward. Pre-1987 unused credit limits may still be carried forward. The Act also severely restricts the use of combination defined benefit and money purchase pension plans by limiting the overall deduction to such plans to 25 percent of compensation. Beginning in 1986, an employer's contribution to a profit sharing plan is not limited to the employer's current or accumulated profits, and for pension plan terminations, any assets reverting to the employer are subject to a 10 percent excise tax.

Employee leasing. The Act, (1) raises the safe harbor contribution rate for the leasing company from 7.5 percent to 10 percent; (2) requires the leasing company to cover 100 percent of its employees; and (3) provides that the safe harbor may not be used if more than 20 percent of the individuals performing substantial services for the recipient organization are leased employees. Thus, the practice of firing all employees (other than the owners) and immediately leasing them back will generally result in disqualification of any qualified plan which only covers the remaining owner-employees.

Compliance. All qualified plans must comply in operation with the Act's changes as of the stated effective dates. However, plans do not have to be amended until the last day of the first plan year beginning after December 31, 1988. Such amendments must apply retroactively to the applicable effective date.

Summary. The underlying theme of the pension changes described above is that tax qualified plans should provide true employee benefits as opposed to providing a tax shelter for the owners and other highly compensated employees of the employer. The biggest setbacks under the new law to using qualified plans to shelter the income of the highly compensated employees are: (1) the actuarial reduction of the $90,000 defined benefit limit when the normal retirement age is under 65 years; (2) the deduction limit of 25 percent of compensation for combination defined benefit and money purchase pension plans; (3) the virtual elimination of "comparable" plans for most small employers; (4) the cutbacks on integration with social security; and (5) the stricter coverage tests.

Despite these new limitations, qualified plans still provide the ultimate tax shelter. Under the Act, joint taxpayers with taxable income between $71,900 and $149,250 ($43,150—$89,560 for single taxpayers) will be in a marginal income tax bracket of 33 percent. Therefore, at these income levels, 33 cents of every dollar contributed to the plan is saved in current income taxes. Moreover, the biggest benefit of all to a qualified plan lies in its tax-deferred earnings growth, and the longer the funds accumulate tax-deferred, the bigger the benefit. ☐

Professional corporations: should they continue?

By Earl L. Romans

Each corporation should be reviewed and analyzed by a CPA or tax attorney, but following are aspects that can be discussed in general terms.

The decision to continue as a PC primarily will be determined by the new corporate and individual rate structure. When tax reform is entirely phased-in in 1988, a corporation can pay less in tax than a high earning individual. For example, if the corporation earns $75,000 or less, the tax will be 15 percent on the first $50,000 of taxable income with the remaining $25,000 being taxed at 25 percent. This is less than the 28 percent individual tax bracket. In contrast, a corporation with earnings in excess of $75,000 may pay taxes that would be higher than the individual owners.

Corporations that project earnings in excess of $75,000 in the future may desire to review the options of electing to be treated as a Sub-Chapter S corporation (Sub-S) or liquidating the existing PC corporation and operating as an unincorporated entity prior to 1988. In order to properly determine whether electing Sub-S or liquidating is the correct course of action, the PC shareholders must decide if the taxable income of the corporation can be reduced below $75,000. This may occur by amending and restructuring the corporate retirement plans which may increase the deduction stream and reduce taxable income.

The extensive tax reform has raised the question as to whether the professional corporation (PC) should be used in the future.

Deductions that can be converted from the PC shareholders to the corporation will also reduce the corporate taxable income. If after enhancing the corporation's deduction stream the taxable income exceeds $75,000, the PC must consider Sub-S liquidation to achieve the best tax position under the new tax reform.

The benefits of electing Sub-S are twofold: The corporation can maintain the corporate shield for legal liability purposes (not malpractice) while allowing corporate taxable income to be taxed at the maximum individual rate bracket or 28 percent. When evaluating the benefits of electing Sub-S it is necessary to discuss the fringe benefits that will be lost by those shareholders owning two percent or more of the corporation. These fringe benefits which would no longer be tax free are:

- Up to $50,000 group term life insurance;
- Accident and health payments;
- Meals and lodging furnished for the convenience of the employer;
- Cafeteria benefit plan.

Ordinarily these fringe benefit being lost by certain shareholder should not be a major determining factor since the deductibility and tax benefit of these costs are relatively small. It is proper to note that rules relating to retirement plans in either a Sub-S o a regular C corporation (PC) are substantially the same.

If electing Sub-S is not favorable the PC shareholders may want to consider liquidating the corporation. Generally if physicians are practicing as a C corporation and desire to continue with the same group in the future, it would be wise to evaluate and perhaps elect Sub-S. I the physicians are planning for retirement and splitting up the current PC, operating as an unincorporated entity may satisfy the goals of certain physicians. Operating as an unincorporated entity provides very few benefits other than simplicity and less administrative cost. In my judgement the negatives of unincorporated ownership certainly outweigh the positives. The negative factors are mostly legal:

- Malpractice claims of associate physicians can affect the assets of all the physicians practicing in an unincorporated business;
- Legal claims resulting from the work-related problems of common law employees will not be limited to the assets of the unincorporated business;
- Health insurance payments for physician/owner are not directly deductible against business income. ☐

The author, Earl L. Romans, CPA, MST, is founder of his own CPA firm in Southfield. The firm primarily serves health care and related service industries.

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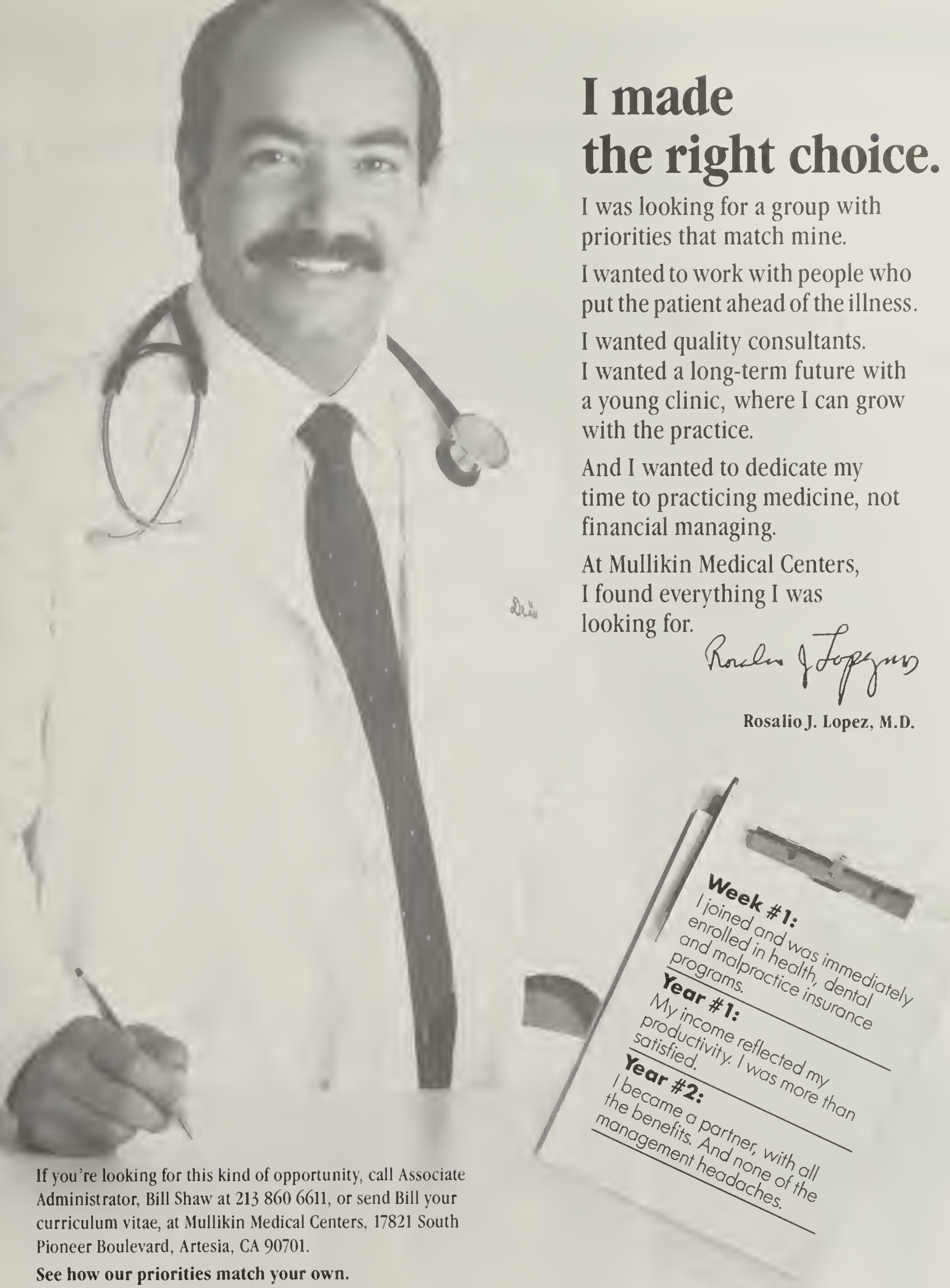

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Miscellaneous tax provisions affect your practice

By Earl L. Romans

Business meals and entertainment

All businesses must comply with the provisions relating to meals and entertainment. Under the new law, 20 percent of these expenses will not be deductible in 1987 and thereafter. The cost of entertainment and meals includes taxes, tips and parking. The cost of travel for meals and entertainment remains 100 percent deductible.

Method of accounting/year ends

Under the new law, small businesses with gross receipts of $5 million or less can continue using the cash method of accounting. If you are beginning a new business the cash method is available unless the business is deemed to be a tax shelter. New businesses generating a loss in the initial years will not be considered a tax shelter simply based on the lack of earnings. The nature of the business will continue to be a more significant factor.

Personal Service Corporations (PSC) must change their accounting year to conform with the calendar year. This change will occur during 1987 and may require the closing of a corporate year twice. Physician corporations (PCs) will be required to conform to the new provisions. It is important to plan the corporate profit for 1987, since the short period tax will not be deferred. The short period profit of a PSC will be taxed as incurred and will be subject to the annualization rules. The annualization rules will usually increase the tax during short periods by overriding the graduated rate schedules.

This brief discussion will familiarize physicians with certain provisions, but additional reading and a visit with tax advisors are recommended.

Depreciation/investment tax credit

Investment tax credit (ITC) on property placed in service after December 31, 1985, will generally not be allowed. Several transition rules apply to property purchased or constructed under binding contracts; however ITC will be easy to handle in the future since it has been repealed. ITC carry-forwards will be reduced in 1987 and thereafter.

Depreciation rules have not changed significantly under the Reform Act for medical practice. The following chart shows the changes in useful lives for the property most often purchased by a medical practice.

Useful life (years)

Description	Old law	New law
Automobiles	3	5
Computers, typewriters, copiers	5	5
Medical equipment	5	5
Office furniture	5	7
Telephone equipment	5	7

The useful life for residential rental properties and commercial properties, such as office buildings has been increased from 19 years to 27.5 and 31.5 years, respectively.

Depreciation methods have also changed and unlike many of the provisions of the new law, have in some cases been liberalized. The new methods will accelerate the write-off of office and medical equipment in 1987 and thereafter.

Luxury automobiles (cost: $16,000 or over) have special depreciation rules. In the future, these automobiles will be depreciated slower than in prior years.

In 1987 and subsequent years, taxpayers are allowed to expense $10,000 of normally capitalized costs rather than depreciating these costs over a period of years. The expensing election is phased out dollar for dollar for taxpayers with cumulative purchases, in any year of more than $200,000 in equipment. ☐

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0,073 patients (90%) who started on NDERAL® LA stayed on INDERAL LA.[1]*

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urprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.

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ole therapy or concomitant therapy? ifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were controlled merely with the addition of a diuretic to INDERAL LA.

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Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

Control, comfort, and compliance

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

The one you know best keeps looking bette

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable

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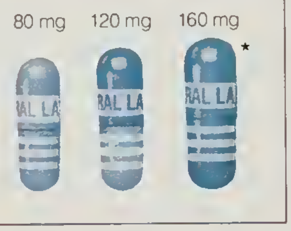
INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES



INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability o heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-re tor agonists and its effects can be reversed by administration of such agents, e g , dobutar or isoproterenol However, such patients may be subject to protracted severe hypoten Difficulty in starting and maintaining the heartbeat has also been reported with beta bloc

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appeara of certain premonitory signs and symptoms (pulse rate and pressure changes) of a hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more diffic adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroic Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of sympt of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function t

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have b reported in which, after propranolol, the tachycardia was replaced by a severe bradyca requiring a demand pacemaker In one case, this resulted after an initial dose of 5 propranolol

PRECAUTIONS. *General* Propranolol should be used with caution in patients with impa hepatic or renal function INDERAL (propranolol HCl) is not indicated for the treatme hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure Patients sh be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lea return of increased intraocular pressure

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart dise elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as re pine should be closely observed if INDERAL is administered The added catecholam blocking action may produce an excessive reduction of resting sympathetic nervous ac which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthos hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals been conducted to evaluate toxic effects and carcinogenic potential In 18-month studi both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of si cant drug-induced toxicity There were no drug-related tumorigenic effects at any of dosage levels Reproductive studies in animals did not show any impairment of fertility that attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in an studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women INDERAL shoul used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers INDERAL is excreted in human milk. Caution should be exercised w INDERAL is administered to a nursing woman

Pediatric Use Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have ra required the withdrawal of therapy

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypo sion, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of Raynaud type

Central Nervous System lightheadedn mental depression manifested by insom lassitude, weakness, fatigue, reversible me depression progressing to catatonia vi disturbances, hallucinations; an acute rev ible syndrome characterized by disorienta for time and place, short-term memory emotional lability, slightly clouded sensor and decreased performance on neuropsy imetrics

Gastrointestinal. nausea, vomiting, epi tric distress, abdominal cramping, diarr constipation, mesenteric arterial thromb ischemic colitis

Allergic pharyngitis and agranulocyt erythematous rash, fever combined with aching and sore throat, laryngospasm and respira distress

Respiratory bronchospasm

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purp

Auto-Immune In extremely rare instances, systemic lupus erythematosus has bee ported

Miscellaneous alopecia LE-like reactions, psoriasiform rashes, dry eyes, male impote and Peyronie's disease have been reported rarely Oculomucocutaneous reactions invol the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride sustained-release capsule for administration once daily If patients are switched from INDE tablets to INDERAL LA capsules, care should be taken to assure that the desired therape effect is maintained INDERAL LA should not be considered a simple mg for mg substitut INDERAL INDERAL LA has different kinetics and produces lower blood levels Retitration be necessary especially to maintain effectiveness at the end of the 24-hour dosing interv

HYPERTENSION — *Dosage must be individualized* The usual initial dosage is 80 INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may increased to 120 mg once daily or higher until adequate blood-pressure control is achie The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of mg may be required The time needed for full hypertensive response to a given dosag variable and may range from a few days to several weeks

ANGINA PECTORIS — *Dosage must be individualized* Starting with 80 mg INDERAL once daily, dosage should be gradually increased at three to seven day intervals until optin response is obtained. Although individual patients may respond at any dosage level, average optimum dosage appears to be 160 mg once daily In angina pectoris, the value safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks WARNINGS).

MIGRAINE — *Dosage must be individualized* The initial oral dose is 80 mg INDERAL once daily The usual effective dose range is 160-240 mg once daily The dosage ma increased gradually to achieve optimum migraine prophylaxis If a satisfactory response is obtained within four to six weeks after reaching the maximum dose, INDERAL LA the should be discontinued It may be advisable to withdraw the drug gradually over a peri several weeks

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are limited to permit adequate directions for use

*The appearance of these capsules is a registered trademark of Ayerst Laboratories

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REFERENCES:

1. INDERAL LA National Compliance Evaluation Program Data on file, Ayerst Laborator
2. Ravid M, Lang R, Jutrin I: The relative antihypertensive potency of propranolol, oxpren atenolol, and metoprolol given once daily *Arch Intern Med* 1985,145 1321-1323

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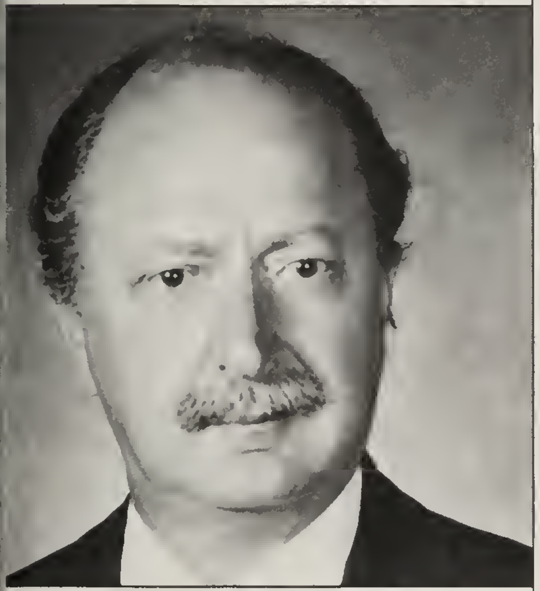
Due process is a time consuming protection

By Thomas J. DeKornfeld, MD



Thomas J. DeKornfeld, MD

Last month in this column I discussed some of the regulatory activities of the Board. This month I will try to complete this discussion.

The brief discussion in last month's column only scratches the surface of the regulatory process. In theory, at least, and largely in practice also, it is a good system.

It has one very vexing problem, however, and that is the time which may elapse between the initial receipt of the allegation by the Department and the time the final order of the Board goes into effect. There are potential delays all along the way, none of which are under the control of the Board.

It may take three or four years for the Board of Medicine to investigate and act upon an allegation. But that is just the price one pays to live in a democratic legal system.

First, the case may not even come to the attention of the Department until many months, or even years, after the alleged violation of the Code has taken place. In a complicated case the investigation may take several months.

The compliance conference must be scheduled with the approval of both the respondent and his/her attorney and the Attorney General. It is not at all uncommon that the conference is postponed at least once. Then the hearing has to be scheduled—now three parties' schedules have to be accommodated. The respondent, the attorney, the Attorney General and the hearing officer all have to be at the same place at the same time. Any one of these parties can ask for an adjournment.

Again, many weeks or even a month or two can go by until the hearing is finally held. Then it may take quite some time until the findings of fact and conclusions of law are transmitted to the Board.

Last, but surely not least, the respondent physician can ask a court to stay the sanction and remand the case to the Board for reconsideration. In this latter case the physician continues to practice until the entire cycle is completed one more time. The end result is that the time elapsed from the original allegation to the final action may, in exceptional cases, be as much as three to four years.

Frustration

Nobody is more frustrated by this than the Board and yet there is very little that can be done about it without violating the due process requirements of the Code. I guess it is just the price one has to pay for living in a democratic legal system where the "accused" is innocent until proven guilty and until all possible avenues of delay have been exhausted. Yet the most widely heard complaint against the Board is that it takes so long to get the license of a "bad" doctor away from him/her. C'est la vie.

Since any physician whose license was suspended or revoked may apply to the Board for reinstatement, this last of the steps in the disciplinary process appears on the Board agenda with some regularity. If the suspension was for six months or less, the suspension automatically reverts to the pre-suspension status at the expiration of the time of suspension. If the suspension was for more than six months the physician must appeal to the Board for reinstatement. If the sanction was one of revocation, the physician

Continued on next page

The author, Thomas J. DeKornfield, MD, is administrator, Michigan Board of Medicine.

DUE PROCESS/Continued

cannot apply for reinstatement for a period of three years. All applications for reinstatement must be accompanied by affidavits supporting the application and indicating that the applicant is capable of practicing medicine in an efficient and safe manner, that the applicant is of good moral character and that the reinstatement is in the public interest.

The applications for reinstatement present the Board with a difficult problem. Obviously a sanction of this severity was not imposed lightly and is done only for a serious violation of the Public Health Code. In general the violations fall into one of three broad categories. These are: (1) The competency issues, i.e. where the physician's ability to practice in a safe and efficient way was questioned because of a bad result due to negligence, carelessness or ignorance; (2) Temporary incapacity due to alcohol or controlled substance abuse or a neuropsychiatric disorder; and, (3) A "criminal" activity which is reasonably related to and adversely affects the physician's ability to practice medicine. There also are a number of "prohibited acts" which are enumerated in the Code (333.16221 (c) and which, if substantiated, will lead to severe sanctions.

Once a sanction has been imposed for any one of these violations, the burden of proof is on the physician. He or she must satisfy the Board that if the license were restored, the physician could practice in a safe and efficient manner, that the physician has proven by clear and compelling evidence that he/she is of good moral character and that the reinstatement is in the public interest. This is not easy to do.

An application for reinstatement is reviewed by the Attorney General. If the AG opposes the application, it goes to a hearing by the administrative law hearing officer, who again drafts findings of fact and conclusions of law. These go to the Board for decision.

If the AG does not oppose the application, then the application with its supporting documentation goes to the Board directly. If the applicant wishes to appear before the Board rather than go to the hearing officer this can be arranged, provided both the applicant and the AG agree to stipulate and waive the findings of fact and conclusions of law. Ordinarily this is the only situation where the physician actually appears before the Board to plead his/her own case. This hearing before the Board is held under oath and a court reporter is present to record the entire proceeding.

Following either of these routes, the Board votes to reinstate or to deny the application. The Board also can attach conditions to the reinstatement, such as probation, limit to the license and/or additional education.

Next month the Board of Medicine column will be written by Board Chairman Charles C. Vincent, MD. ☐

Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: James Allen Bennett, MD
Action, Date Taken: Reprimanded, suspended thirty (30) days (reinstatement *not* automatic) and probation for two (2) years following reinstatement — July 16, 1986
Reason: Convicted of a crime reasonably related to and adversely affecting his ability to practice in a safe and competent manner (failure to file income tax return).

Name: Bruce L. Danto, MD
Action, Date Taken: Fined $5,000.00. Effective July 16, 1986
Reason: Convicted of a crime reasonably related to and adversely affecting his ability to practice in a safe and competent manner (failure to file income tax return).

Name: Talmadge G. Hiebert, MD
Action, Date Taken: Suspended one (1) year, December 4, 1986
Reason: Action modified from revocation to suspension by First Amended Final Order dated November 4, 1986.

Name: Barry G. Siegel, MD
Action, Date Taken: Board order revoking license on August 1, 1986 stayed by order of the Circuit Court for the County of Ingham, July 18, 1986.

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New hope for sudden death survivors

By Michael H. Lehmann, MD

It seems like an ordinary Tuesday evening in the Jones' household. Mr. Jones, a 53-year old factory worker, and his wife are in the living room watching an after-dinner sitcom on television. During a commercial break, Mrs. Jones goes to the kitchen to bring back a snack. Upon returning one minute later, she is shocked by the sight of her husband who appears ashen gray, slumped in his chair and unresponsive. Keeping her panic under control she calls the local paramedic squad which arrives within minutes. Cardiopulmonary resuscitation is initiated but Mr. Jones continues to be pulseless and apneic. Only after electrical cardioversion is performed do his heartbeat and breathing return.

This hypothetical—yet typical—scenario vividly describes the catastrophic condition known as "sudden cardiac death." Each year some 5,000 Michiganians are not as lucky as Mr. Jones and succumb to this often fatal syndrome.

Sudden cardiac death, by definition, strikes an individual (who is typically a middle-aged male) with minimal or no apparent warning signs. We know that in about 80 percent of cases, the mechanism responsible for this cular fibrillation, often triggered by ventricular tachycardia. Most sudden death victims have significant underlying coronary artery disease (known or occult), although, contrary to a widely held belief, evidence of an acute coronary occlusion is present in only 20 percent of these individuals.

With the widespread availability of paramedic teams, we are seeing such individuals in ever-increasing numbers.

Unfortunately, it is very difficult to predict in advance whether someone will succumb to sudden cardiac death, precisely because potential victims often appear to be in otherwise good health. Individuals lucky enough to have had an aborted episode of sudden death, on the other hand, collectively comprise a clear target for our most intensive efforts, since these people have a 15-30 percent yearly reccurence rate of the fatal syndrome. Indeed, with the widespread availability of paramedic teams throughout the state, we are seeing such individuals in ever-increasing numbers.

The traditional approach to treating sudden death survivors has stressed utilization of antiarrhythmic therapy with the purpose of suppressing spontaneous premature ventricular beats. The underlying assumption is that if such relatively benign abnormal beats can be suppressed, then emergence of truly malignant ventricular arrhythmias will be similarly prevented. Physicians, however, have no way of knowing whether they are using the correct drug at an adequate dose in order to achieve this ultimate goal. Consequently, it is difficult to ascertain whether empiric anti-arrhythmic therapy can truly protect a sudden cardiac death survivor from a fatal recurrence.

An alternative and more precise new approach has gained popularity in recent years. This method, called electrophysiologic testing, involves the insertion of temporary cardiac pacing wires via peripheral veins. Under very controlled and safe conditions, electrical pacing techniques are then employed to actually induce the very arrhythmia which nearly led to the patient's demise. Once induced, the malignant arrhythmia is promptly brought under control with either overdrive pacing or direct current cardioversion. The ability to safely reproduce life-threatening rhythm disturbances in patients who have experienced aborted sudden death allows the physician to determine whether or not a given antiarrhythmic agent truly reduces susceptibility to spontaneous development of a lethal arrhythmia.

Another exciting new development in this evolving area of cardiology has been the advent of

Continued on page 70

The author, Doctor Lehmann, is associate professor of medicine, Wayne State University Division of Cardiology, and director, electrophysiology laboratory and arrhythmia service, Harper Hospital. This article is presented as an expansion of our regular Medical Newsfronts department.

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SUDDEN DEATH/Continued

the automatic implantable cardioverter-defibrillator (AICD). This device, which is now becoming available for the first time in Michigan, is implanted surgically. Two thin flexible wire patches are sutured to the surface of the heart and, along with two screw-in epicardial electrodes, are connected to the device which is placed in a subcutaneous abdominal pouch. The AICD, therefore, can continuously monitor the cardiac rhythm. When the device senses the occurance of ventricular tachycardia or fibrillation, it delivers a lifesaving shock (typically in the range of 25 joules) via the epicardial patches.

It is anticipated that wide spread utilization of both electrophysiologic testing and the AICD in the coming years will contribute to a significant decrease in the number of individuals falling victim to sudden death, both in Michigan and throughout the United States. ☐

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Nuclear war: no treatment, no cure

By Carole Eberly

The following article is a report on a presentation by Christine K. Cassel, MD, FACP on "Physicians' Role in Shaping the Nuclear Arms Debate." Doctor Cassel, associate professor of medicine at the University of Chicago Pritzker School of Medicine, spoke as part of a Distinguished Speakers Series sponsored by MSU's Medical Humanities Program and Ingham Medical Center, Lansing.

Nuclear war is an issue of medical prevention because there is no cure or effective treatment, says Christine K. Cassel, MD, FACP, president of the Society for Health and Human Values and president-elect of Physicians for Social Responsibility (PSR).

She reminded a medical audience recently that 95 percent of all physicians and nurses were killed and all hospital facilities destroyed by the nuclear explosions in Japan during World War II.

"Doctors cannot be expected to mop up the damage afterward," she said. "That may seem to you self-evident and almost a redundant statement. But it is worth the exercise if you consider there are national plans that involve physicians in disaster planning for the consequences of nuclear war."

She predicts that during the "standard" 6,500 megaton attack, 134 million persons in the US will die from flash burns, trauma, secondary fires, debris, dehydration, fallout radiation and inadequate ventilation in shelters "for people unfortunate enough to be in shelters, which will probably become crematoria." Another 33 million will be injured.

She said suggested prevention efforts range from the impossible to the ridiculous. One is a do-it-yourself shelter where you dig a hole in the ground, put your car over it and sit under it until it all blows over.

Absurdity

It was the PSR and other citizens groups who in the early 1980s brought the absurdity of these plans to the public's attention. In many places they got city councils to reject federal funding linked to development of evacuation plans.

Doctor Cassel said the full implications of nuclear war still are unknown. One known phenomenon is the superfire—a fire that feeds on itself to generate an inward hurricane of superheated flames that greatly increase the radius of destruction.

She also warns of the depletion of the stratospheric ozone layer which, even four years after a war, will allow enough ultraviolet radiation through the atmosphere to give human beings second degree burns in just 20 minutes of exposure to sunlight. Animals, who need sight in order to live, will be blinded.

"The whole eco-chain will be destroyed by this single atmospheric complication," said Doctor Cassel.

In addition, so much ash will be present following a nuclear war that there will be a dark, cold period where the earth's surface temperature could be as low as zero degrees Fahrenheit for three months.

"People will freeze," she said. "There will be no hope of anything growing. And of course, once the nuclear winter clears, we will have the ozone layer to contend with. Not very reassuring."

"Star Wars" fantasy

She said the whole issue of "Star Wars" offering protection from such devastation is just a fantasy.

"It's an appealing fantasy now that the public is terrified of nuclear weapons and understands that you can't survive," she acknowledged. "People want to believe there can be a technical fix to this problem—that the same technology that brought you the risk can also bring you the solution. I understand why people are attracted by that idea Americans in general like technical solutions. But you as physicians know that technical solutions are not always the most effective ways of dealing with problems."

Doctor Cassel said, with a 50,000 megaton total war ar-

The author, Carole Eberly, is a Lansing-area freelance writer.

enal, is it not unthinkable that 00 megatons would find their targets. Even government officials have said "Star Wars" would only be 95 percent effective.

With that statement, Doctor Cassel opened a black umbrella with large holes dotting its surface.

"The holes represent five percent of the surface area," she said. "If you were using it during a rainstorm, you would be very wet. I suggest if you were using it during a nuclear war, you would be very dead."

In addition, she said estimates put the figure at $1 trillion for the first five years of "Star Wars" installation. Doctor Cassel suggested that money could be better spent on health care, which generates eight to ten times as many jobs per dollar than defense.

A message of despair?

She said polls now show most Americans think they would not survive a nuclear war.

"What then?" She asked. "We just can't leave people with this message of despair. If the logical conclusion is that these weapons cannot win any war and therefore have no political usefulness, than the next logical conclusion is that we have to get rid of them. They are lethal, they are intruders in our civilization and we have to somehow get the power to turn the arms race around. That is something physicians can be involved in," she added. "It's not enough for us to make the diagnosis, we also have a responsibility to work on the prescription."

Doctor Cassel pointed out that the role of physician as educator and political activist is not a recent one. She cited the disappearance of smallpox from the world and the advent of mandatory car seats for infants as examples of physicians working to solve a health problem through education and politics.

"The more we understand about this business, the greater our responsibility to do something about it," she said. "I'm often asked how I can spend my time—and as a physician I have so little spare time—thinking about nuclear weapons and all of this gory, disaster stuff. 'Isn't it depressing?' "

"My answer is, once I know what I know, I can't *not* know it anymore," she added. "There has to be some response to this information which is sobering and desperately important."

"But, it is in fact an invigorating way to deal with it, to take responsibility on a professional level."

PSR is no longer a small fringe group operating out of Harvard, she said. More than 50,000 physicians—one out of every ten—now belong to it.

"There's a reason for this," she said. "Once you understand the scientific issues of nuclear war, you realize this is not a partisan debate. It doesn't have to do with Republicans or Democrats or liberals or conservatives. It has to do with the nature of knowledge which is empowering. That's the basic role physicians play."

Doctor Cassel said physicians are going to have to find a way to work on nuclear arms reduction for the rest of their lives if they are to be successful.

"If we're not successful, we don't have to worry about it," she added.

An effective treaty

She said it is madness for the US to build three to five nuclear weapons each week to add to an arsenal of 50,000.

Reducing weapons bilaterally with the Soviet Union is possible if Americans get away from the idea you have to trust the Russians.

"An effective treaty is based on mutual self-interest and verification," she said. "We can have both of those right now."

She said satellite surveillance now allows each nation to see what the other is doing. She added that a private group of American scientists, the Natural Resources Defense Council, has struck an agreement with the Soviets to allow them to place on-site seismic monitors at test sites. A group of Soviet scientists are hoping to do the same in the US.

"More nuclear weapons don't make us more safe," Doctor Cassel said. "They make us less safe. We're more likely to use them. It's the use-it-or-lose-it mentality. If either side uses them, we both are destroyed."☐

Newberry's amazing doctor production

By Lawrence Grennan, MD

If you drive through Newberry, chances are you will get the impression of a pleasant, somewhat poor village. Most people passing through are much more interested in the beautiful lakes, streams and forests of the eastern Upper Peninsula than they are in the communities. Certainly almost no one would guess that Newberry is a consistent exporter of talented young people.

I lived in and practiced medicine in Newberry for nine years. Gradually, after hearing about many of the sons and daughters who made a success in business and the professions, but especially in medicine, I realized that it was remarkable. After all, Newberry has only 2,190 people. It is the county seat of Luce County which has 6,659 residents. The schools have always been good but they have always had financial problems as well as a narrow curriculum common to most small school systems. People there can live and die as licensed drivers without ever seeing a green and red traffic light. There are only some blinker lights out on M-28.

From my reading, I knew that very large cities and very small ones do not produce enough doctors to fill their own needs. It is said that medium-sized cities produce more than their share. Therefore when I considered the modest incomes of the people in this country, it seemed all the more remarkable that they could help a child through years of college and medical school.

Speculation about why this small Michigan town has produced so many outstanding young people has provided no real answers.

The next step in documenting this phenomena was to compile a list of doctors who originated in Newberry. A number of local people with good memories supplied this information. We decided to limit our list to those who had graduated from Newberry High School. We knew of individuals like Peter Carmody, MD, who finished school in other communities and then became physicians. Thomas Berglund, MD, our current MSMS president went to Newberry High School but transferred before graduation.

The final work of checking out the list was done by Mary Lou Hicks, wife of physician Sam Hicks. Liz Decator helped with checking school records. It is possible that we missed some, but the list as compiled totals 21 MDs and two DOs.

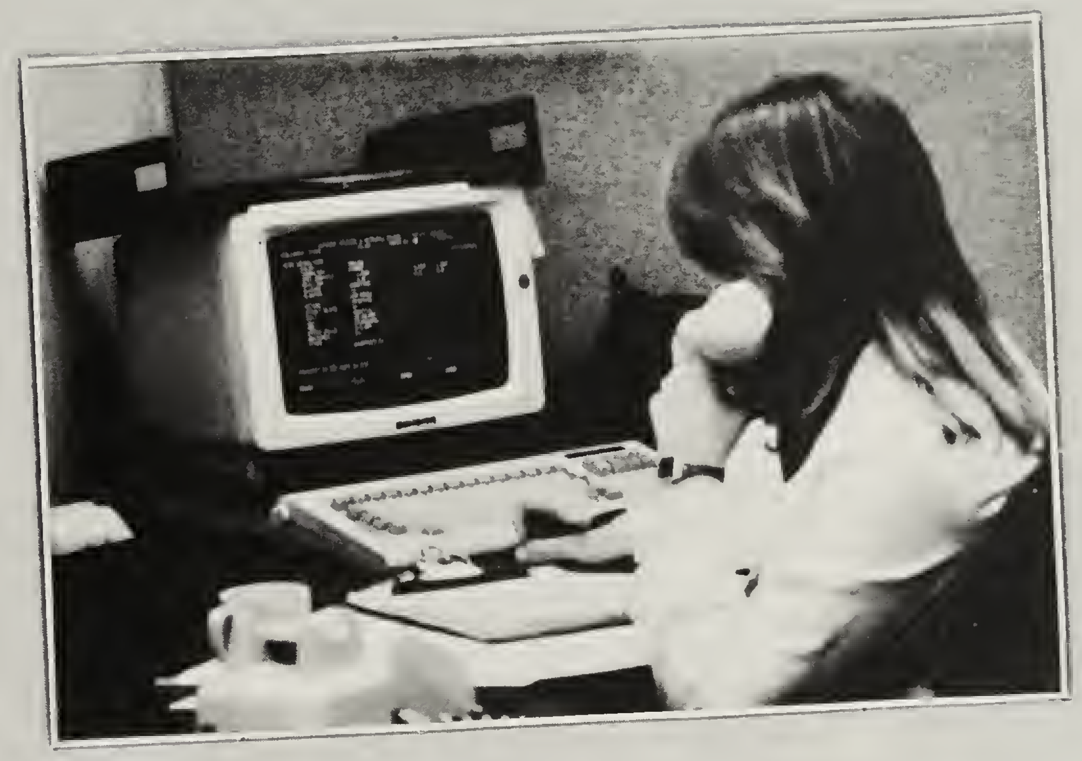
Speculation about why Newberry has produced more than its share of outstanding young people has not come up with any definite answers. Certainly the school system had to be good. Newberry for years was the site of the Newberry State Hospital, now a regional mental health center. Physicians on the staff may have provided an example for young people thinking about a career. However, only one on our list, Mary Baker Whitmer, DO, was the child of a state hospital physician. There are few people of means in Newberry, so it took great courage for most parents to agree to finance a medical education.

Whatever the reason, it is amazing!!

Newberry-bred doctors of medicine include: George Swanson, MD, (deceased); Carl Hedberg, MD; Robert E. Gibson, MD; James H. Fyvie, MD, (deceased); Mathew Surrell, MD; Laura Kronquist Mesaros, MD; Victor A. Berglund, MD; Floyd G. Goodman, MD; Joseph L. DeCook, MD; Robert Willis, MD; Robert D. Gibson, MD; Larry J. Sell, MD; James A. Surrell, MD; Richard B. Krueger, MD; Neil J. Maki, MD; Wardell S. Hicks, MD; James P. Halbach, MD; Paul M. Dake, MD; Victoria L. Macki, MD; Anne M. Foley Pike, MD, and James F. Beaudin, MD.

Newberry-bred osteopathic physicians are: James E. Harkness, DO, and Mary C. Baker Whitmer, DO. ☐

The author, Doctor Grennan, a Muskegon plastic surgeon, is a former Newberry resident.



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Maternal/child health outreach

Henry L. Nadler, MD, dean of the School of Medicine at Wayne State University, recently announced an award of $508,000 from the Ford Foundation to support an outreach demonstration project directed at improving pregnancy outcomes and infant care in Detroit. The three-year project will be conducted through WSU's Institute of Maternal/Child Health, a multidisciplinary program of the School of Medicine departments of obstetrics/gynecology, pediatrics and community medicine.

The outreach project involves the establishment of a cooperative system of prenatal and well-child care services provided through the Detroit Health Department's Family Health Centers, the Samaritan Primary Care Initiative, Henry Ford Hospital's Adolescent Pregnancy Clinic, Children's Hospital of Michigan and Hutzel Hospital.

The Ford Foundation grant, combined with funding from the State of Michigan and the federal VISTA program, will be used to train and deploy paraprofessionals as maternal and child health advocates to conduct community outreach among hard-to-reach pregnant women and new mothers in the Detroit area. The advocates will assist women in obtaining appropriate health care services within the established network. Additionally, new and expectant mothers will be provided with the education to recognize and respond to their infants' and their own health care needs.

AIDS and pregnancy

"AIDS and pregnancy," a new publication dealing with the most current information on the effects of acquired immune deficiency syndrome (AIDS) on pregnancy and healthy birth, is now available from Maternity Center Association, a national, non-profit health agency dedicated to the improvement of maternal and infant care.

Recent research has indicated that pregnant women who have been exposed to the AIDS virus may have an increased risk both of developing AIDS and of possibly passing it on to their children during pregnancy, birth or through breast-feeding. "AIDS and pregnancy" focuses exclusively on the growing number of women of childbearing age who may have AIDS, have been exposed to the disease, or have unanswered questions or fears about possible risks to their newborns and themselves. It covers such topics as: which women should be tested for the AIDS virus; what to do if the test results are positive; how the disease is transmitted from mother to child; children with AIDS, and the future of AIDS and pregnancy.

"AIDS and pregnancy" is available at 50 cents (30 cents for each 100 or more) from: Publications Department, Maternal Center Association, 48 East 92nd Street, New York, NY 10128.

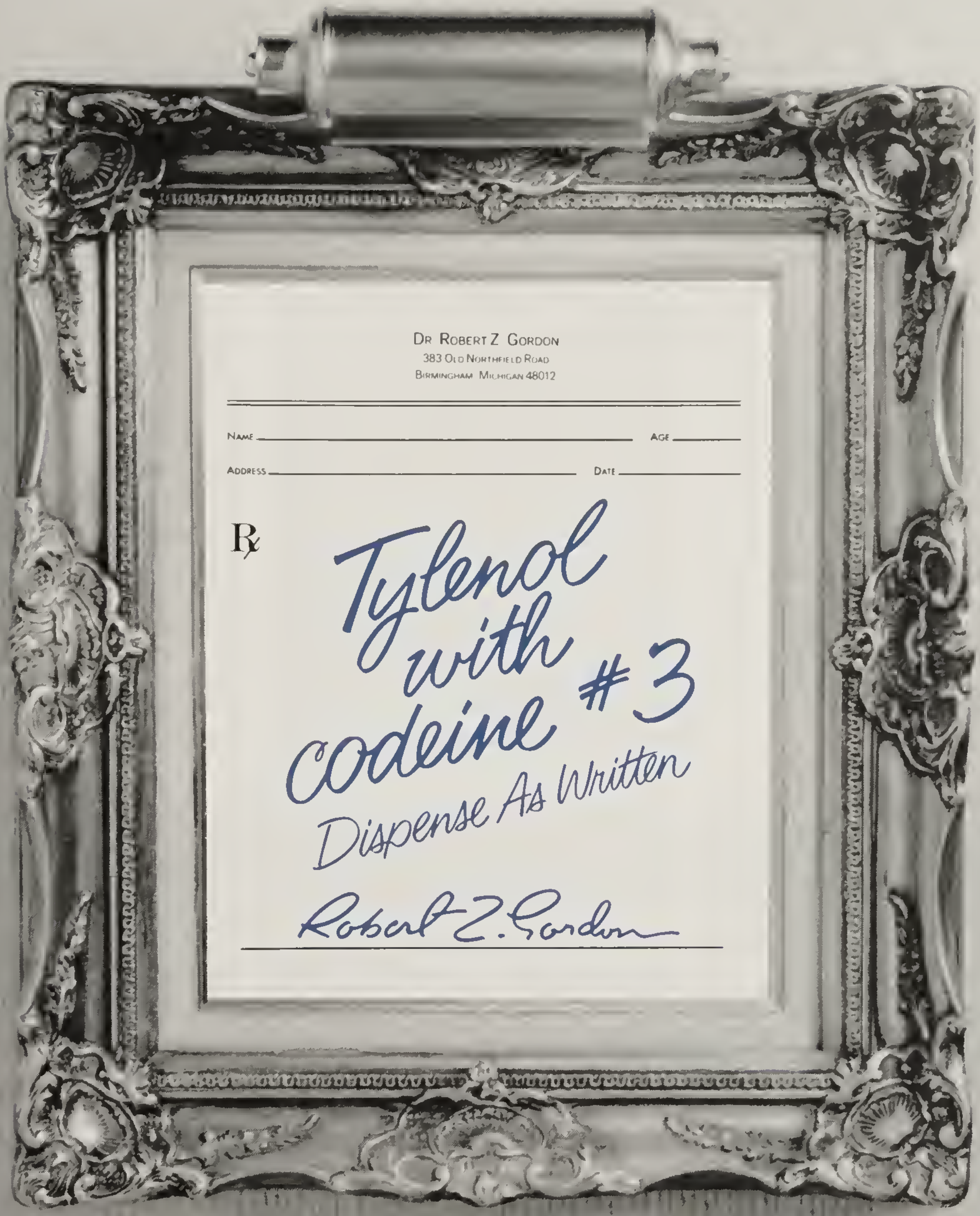
Housing for cancer patients

The University of Michigan Medical Center and the American Cancer Society recently opened a temporary "home away from home" for adult cancer patients, the first of its kind in Michigan.

Known as the Wilmot House, the new facility, 1322 Wilmot Street, Ann Arbor, will provide low-cost housing for radiation oncology patients and their families who live too far away to commute to the U-M Medical Center for extended outpatient radiation therapy.

Sheryl Lozowski, who has been a cancer patient at the Medical Center, is the Wilmot House resident manager. "Wilmot House is unique because it's an adult service for radiation cancer patients," she said. "Cancer patients will be able to come from around the state to take advantage of the house, and can be joined by a family member when necessary. Such patients would normally have to travel a great distance for outpatient services or spend a lot of money for temporary housing at a hotel."

Continued on page 78



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Donations from the public will help defray the cost of operation and help keep room rates low, Lozowski said. Currently, they are $12 per room, per night.

Those wishing to donate goods, services or financial support, or to volunteer, may contact the Wilmot House at (313) 761-1414 or the American Cancer Society at (313)971-4300.

Ehlers Danlos support group

The Ehlers Danlos National Foundation (EDNF) was recently organized in an effort to provide emotional support, knowledge and understanding to those who suffer from this rare disorder and to their families. Ehlers Danlos Syndrome is a congenital defect in the structure of the connective tissue. EDNF also provides informational link to interested physicians who may treat and/or diagnose EDS. The group publishes a quarterly newsletter; maintains a physician referral listing and houses a library.

For more information contact: Ehlers Danlos National Foundation, P.O. Box 1212, Southgate, Michigan 48195 (313)282-0180.

Reye's Syndrome update

Since Oct. 1, 1986 one case of Reye's Syndrome has been reported in Michigan. The three-year-old male from Macomb County

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lied shortly after hospital admis-ion in early November, 1986.

Influenza A (H1N1) "Taiwan-ike" virus has been isolated from 34 states. Influenza B has been isolated from sporadic cases in California and Texas. Influenza A (H3N2) has been isolated from a sporadic case in Arizona. Eleven states reported widespread outbreaks of influenza-like illness for the week ending December 27, 1986.

In Michigan, Influenza A has been isolated from Berrien County, Hancock County and Washtenaw County. The single isolates from Berrien County and Hancock County have been subtyped as H1N1. The Berrien County isolate was associated with widespread influenza-like illness in a school system.

Saginaw County medical history

The Saginaw County Medical Society has published *The History of Saginaw County Medicine.* The 199-page hard bound volume traces the development of medical care from the early 1800s through modern times. The book was written by Anita M. Fisk of Midland, and includes a Foreward by Richard D. Mudd, MD, chairman of the county medical society's historical committee. For details contact Saginaw County Medical Society, PO Box 6033, Saginaw 48608 (517) 752-3152.

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WARNINGS

1. **Cardiac Conduction.** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. **Congestive Heart Failure.** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*

   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. **Acute Hepatic Injury.** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established The most common occurrences as well as their frequency of presentation are: edema (2 4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular.	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic.	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM. alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established

Issued 7/86

See complete Professional Use Information before prescribing.

References: 1. *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347* **2.** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* **3.** *Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687.* **4.** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39* **5.** *Schroeder JS: Calcium and beta blockers in ischemic heart disease. When to use which. Mod Med 1982;50(Sept):94-116.*

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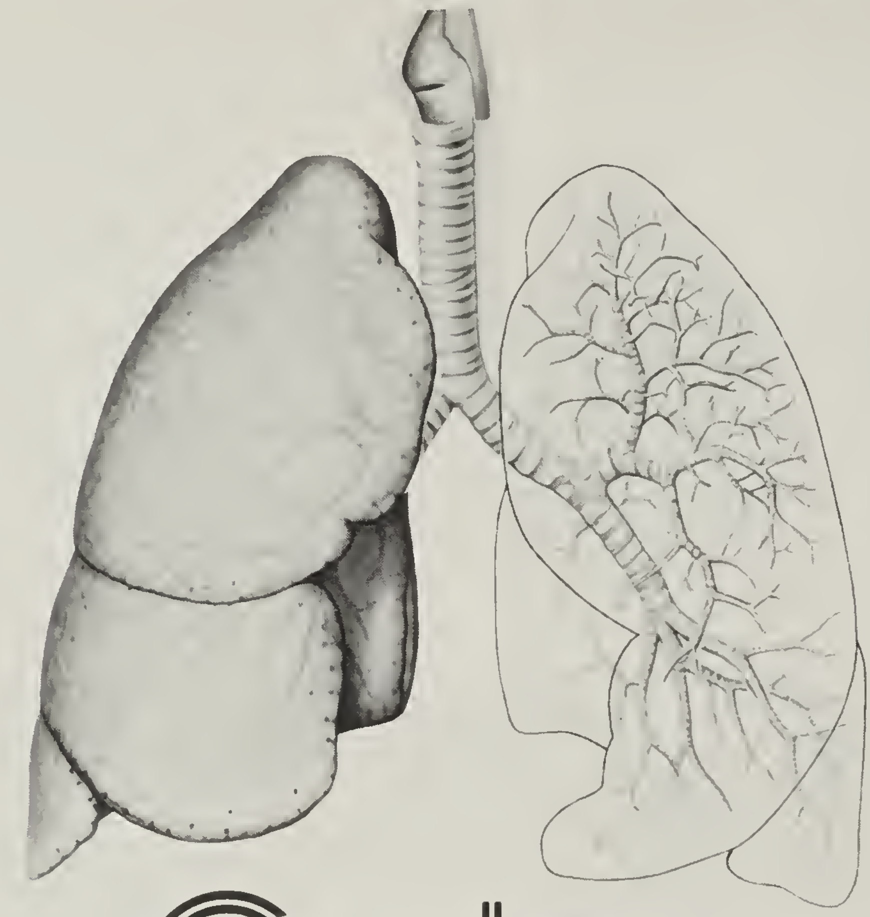

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Note: Ceclor® is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Contraindications: Known allergy to cephalosporins.

Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly)

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These AMA reports are available

The following reports were considered at the AMA House of Delegates Annual Meeting in Las Vegas, December 7-10, 1986. Copies are available by contacting Joyce Crum, MSMS Department of Communications, PO Box 950, East Lansing 48826-0950.

Reports of the AMA Board of Trustees:

Report J—Standard Terminology for Reporting of Reproductive Health Statistics in the United States
Report L—AIDS Status Report
Report BB—Physician Payment for Case Management
Report MM—AIDS Status Report: Update on Recent Developments in HIV Antivirals
Report PP—Strengthening Public/Professional Confidence in AMA: A Strategic Plan
Report TT—Medical Society Referrals
Report YY—Report of the Special Task Force on Professional Liability and Insurance and the Advisory Panel on Professional Liability

Reports of the Council on Ethical and Judicial Affairs:

Report A—Conflicts of Interest
Report B—Statement on AIDS

Reports of the Council on Medical Education:

Report E—AMA Role in Allied Health Education and Accreditation
Report F—Essentials for Approval of Examining Boards in Medical Specialties

Reports of the Council on Medical Service:

Report C—Closing the Gaps in Health Care Funding: Protecting the Low-Income Population
Report L—Peer Review Organization (PRO) Program

Reports of the Council on Scientific Affairs:

Report B—Drug Abuse in Athletes: Anabolic Steroids and Human Growth Hormone
Report C—The Heimlich Maneuver
Report D—Discrimination Against AIDS Patients
Report F—Adverse Health Effects of Video Display Terminals (VDTs)
Report G—Autopsies
Report H—Radon in Homes

Informational Reports of the Council on Scientific Affairs:

Report 1—Cocaine: Phenomenology and Treatment of Abuse
Report 4—Nuclear Magnetic Resonance Imaging: Prologue
Report 5—Nuclear Magnetic Resonance Imaging: Fundamentals
Report 6—Nuclear Magnetic Resonance Imaging: Cardiovascular System
Report 7—Medical Aspects of Pre-Adolescent Participation in Sports
Report 8—Health Fraud Report☐

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RE: Preventing claims through legible handwriting

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A recent study published by two physicians in the New England Journal of Medicine confirms that illegible medical records can be a source of professional liability risk.

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PHYSICIANS IN THE NEWS

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Daniel F. Hoheim, MD, Saginaw, received the first $1,000 Zeile Scholarship as the outstanding medical resident at Saginaw Cooperative Hospitals, Inc.... **George A. Dean, MD**, Birmingham, was invited by the London House of Commons to help celebrate the international meeting of Chess Collectors International, of which he is president.... **Marshall Klaus, MD**, East Lansing, chairperson, Department of Pediatrics and Human Development, Michigan State University College of Human Medicine, was honored recently as one of Case Western Reserve University's distinguished alumni.... **Douglas McKeag, MD**, East Lansing, associate professor of family practice and director of research, Michigan State University College of Human Medicine, recently was appointed by the Governor to the Michigan Department of Public Health Adolescent Health Advisory Committee.... **Joseph R. Hume, MD**, East Lansing, associate professor of pharmacology and toxicology at MSU, recently was the recipient of an Established Investigator Award from the American Heart Association.... **Willard J. Hendrickson, MD**, Ann Arbor, was honored recently with a reception celebrating the 30th anniversary of his founding of the first adolescent psychiatry service, located at the University of Michigan Medical Center.... **Bernard Eisenstein, MD**, Orchard Lake, has been appointed corporate associate medical director for extramural activities of the William Beaumont Hospital Corporation.... **M. Colton Hutchens, MD**, Bloomfield Hills, and **Robert Mast, MD**, Birmingham, recently were appointed associate medical director and assistant medical director, respectively, of William Beaumont Hospital in Troy.... **Paul R. Lichter, MD**, Ann Arbor, has been named editor of *Ophthalmology*, the official journal of the American Academy of Ophthalmology.... **William M. Leuchter, MD**, Southfield, was among three recipients of the State of Israel Maimonides Awards from the Metro Detroit State of Israel Bonds Health Services Division at the group's annual awards dinner.... **Joseph Bowler, MD**, Kalamazoo, has been elected Kalamazoo Academy of Medicine president and **David Doan, MD**, Kalamazoo, was named president-elect.... **Paul D. Croissant, MD**, Bloomfield Hills, recently was elected treasurer of the Oakland County Medical Society; **Robert C. Arends, MD**, Troy, has been elected secretary.... **Joseph C. Honet, MD**, Franklin, has been named Distinguished Clinician of the Year by the American Academy of Physical Medicine and Rehabilitation. ...**Robert P. Locey, MD**, Pontiac, was appointed Oakland County director of institutional and human services by the Oakland County Board of Commissioners.... **Douglas D. Sherk, MD**, Marquette, has been named vice-president for academic and clinical affairs of the Upper Peninsula Health Education Corporation. He also was named assistant dean of Michigan State University's College of Human Medicine.... **William J. Dierberg, MD**, Detroit, recently won the Investigator Award in the Plastic Surgery Educational Foundation's 1986 scholarship contest.... **Willys F. Mueller, MD**, Fenton, was installed as the new president of the Genesee County Medical Society.... The trauma rooms in Hackley Hospital's Emergency Department recently were dedicated to **Osbie J. Herald, MD**, North Muskegon, in honor of his nine years as director of emergency services at Hackley.... The Shiawassee County Medical Society recently presented a plaque to **James H.**

Honet

Lichter

Continued on page 92

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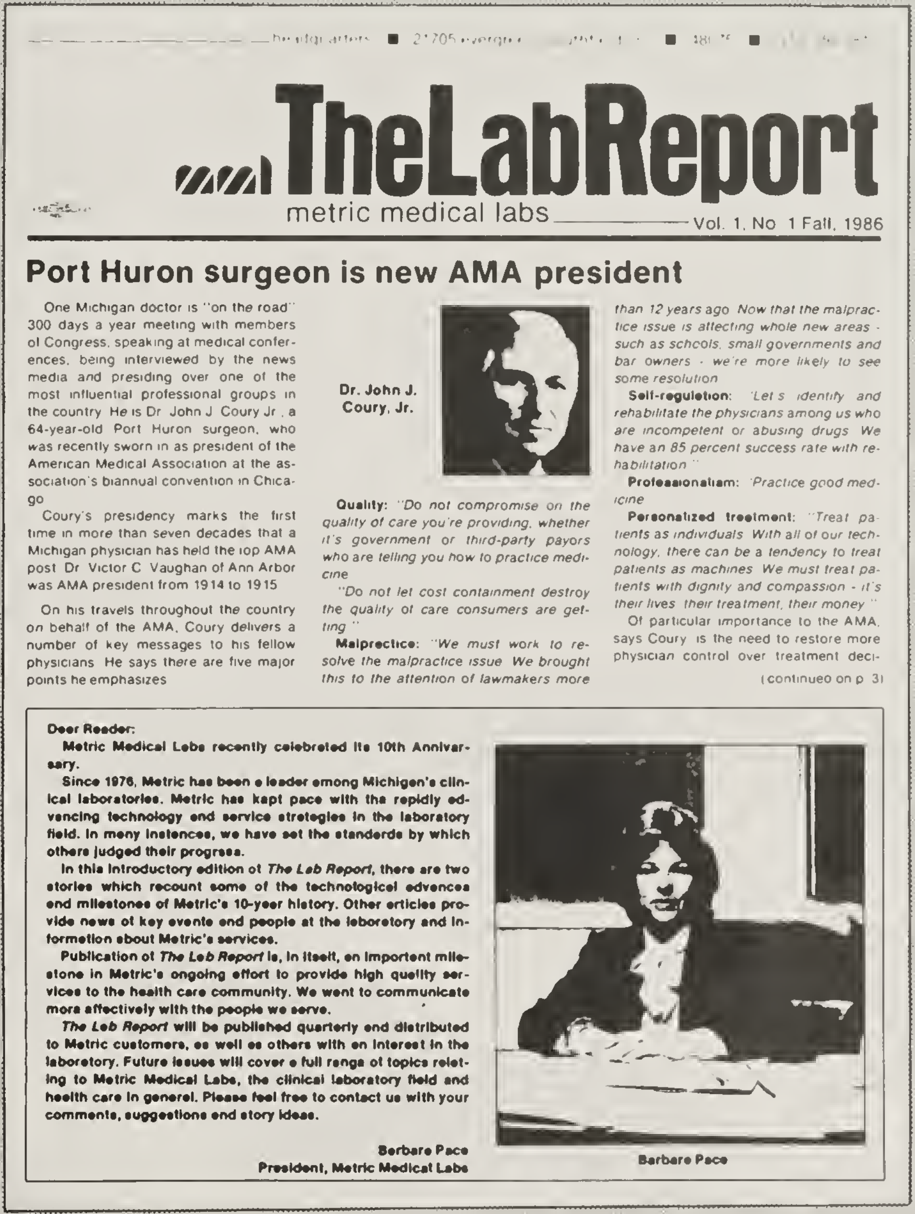

TheLabReport
metric medical labs — Vol. 1, No 1 Fall, 1986

Port Huron surgeon is new AMA president

One Michigan doctor is "on the road" 300 days a year meeting with members ol Congress, speaking at medical conferences, being interviewed by the news media and presiding over one of the most influential professional groups in the country He is Dr John J Coury Jr , a 64-year-old Port Huron surgeon, who was recently sworn in as president of the American Medical Association at the association's biannual convention in Chicago

Coury's presidency marks the first time in more than seven decades that a Michigan physician has held the top AMA post Dr Victor C Vaughan of Ann Arbor was AMA president from 1914 to 1915

On his travels throughout the country on behalf of the AMA, Coury delivers a number of key messages to his fellow physicians He says there are five major points he emphasizes

Dr. John J. Coury, Jr.

Quality: *"Do not compromise on the quality of care you're providing, whether it's government or third-party payors who are telling you how to practice medicine*

"Do not let cost containment destroy the quality of care consumers are getting "

Malpractice: *"We must work to resolve the malpractice issue We brought this to the attention of lawmakers more than 12 years ago Now that the malpractice issue is affecting whole new areas - such as schools, small governments and bar owners - we're more likely to see some resolution*

Self-regulation: *'Let's identify and rehabilitate the physicians among us who are incompetent or abusing drugs We have an 85 percent success rate with rehabilitation "*

Professionalism: *'Practice good medicine*

Personalized treatment: *"Treat patients as individuals With all of our technology, there can be a tendency to treat patients as machines We must treat patients with dignity and compassion - it's their lives their treatment, their money "*

Of particular importance to the AMA, says Coury is the need to restore more physician control over treatment deci-

(continued on p 3)

Dear Reader:

Metric Medical Labs recently celebrated its 10th Anniversary.

Since 1976, Metric has been a leader among Michigan's clinical laboratories. Metric has kept pace with the rapidly advancing technology and service strategies in the laboratory field. In many instances, we have set the standards by which others judged their progress.

In this introductory edition of *The Lab Report*, there are two stories which recount some of the technological advances and milestones of Metric's 10-year history. Other articles provide news of key events and people at the laboratory and information about Metric's services.

Publication of *The Lab Report* is, in itself, an important milestone in Metric's ongoing effort to provide high quality services to the health care community. We want to communicate more effectively with the people we serve.

***The Lab Report* will be published quarterly and distributed to Metric customers, as well as others with an interest in the laboratory. Future issues will cover a full range of topics relating to Metric Medical Labs, the clinical laboratory field and health care in general. Please feel free to contact us with your comments, suggestions and story ideas.**

Barbara Pace
President, Metric Medical Labs

Barbara Pace

The Lab Report is a newsletter that provides laboratory information and health care news to clients of Metric Medical Labs. More than 3,500 Michigan physicians and other health care providers receive *The Lab Report*. For a complimentary issue or more information about **Metric Medical Labs,** call (313) 358-0810, ext. 368.

NEWS/Continued

Park, MD, Owosso, honoring Owosso's Arnold Clinic for a "hundred years of dedicated service"....**Gerhard Endler, MD**, Grosse Pointe Shores, recently was honored at Hutzel Hospital's annual awards dinner for having worked as vice-president of medical affairs and chief of anesthesiology at Hutzel for 25 years.... **Marshall Goldberg, MD**, Burton, an endocrinologist at Hurley Medical Center has written a new book, *Intelligence*, a sequel to his previous novel, *The Karamanov Equations*....**Morris Brown, MD**, Detroit, director of critical care services at Sinai Hospital, spoke at the American Society of Anesthesiologists annual meeting in Las Vegas.... **Fred W. Whitehouse, MD**, Detroit, division of metabolic diseases at Henry Ford Hospital, was a featured speaker in a live satellite teleconference sponsored by the American Hospital Association about diabetes patient education. ...**Mark Novitch, MD**, Kalamazoo, was elected to the Board of Directors of the Upjohn Company....**William H. Heatley**, **MD**, Waterford, recently was elected to a three-year term as a director of the Flying Physicians Association. ☐

A photo in the January issue of *Michigan Medicine* was incorrectly identified as that of Frederick E. Ludwig, II, MD, of Sault Ste. Marie. The photo actually was of Frederick E. Ludwig, MD, Port Huron, the younger Ludwig's father.

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'ore prescribing, see complete prescribing information in SK&F CO.
rature or *PDR*. The following is a brief summary.

VARNING

'his drug is not indicated for initial therapy of edema or hyperten-
ion. Edema or hypertension requires therapy titrated to the individual.
f this combination represents the dosage so determined, its use
nay be more convenient in patient management. Treatment of hyper-
ension and edema is not static, but must be reevaluated as con-
litions in each patient warrant.

ntraindications: Concomitant use with other potassium-sparing agents
:h as spironolactone or amiloride. Further use in anuria, progressive
al or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum
assium. Hypersensitivity to either component or other sulfonamide-
ived drugs.

ırnings: **Do not use potassium supplements, dietary or otherwise,
ess hypokalemia develops or dietary intake of potassium is markedly
paired**. If supplementary potassium is needed, potassium tablets
ould not be used. Hyperkalemia can occur, and has been associated
h cardiac irregularities. It is more likely in the severely ill, with urine
ume less than one liter/day, the elderly and diabetics with suspected
confirmed renal insufficiency. Periodically, serum K⁺ levels should be
ermined. If hyperkalemia develops, substitute a thiazide alone, restrict
intake. **Associated widened QRS complex or arrhythmia requires
ompt additional therapy**. Thiazides cross the placental barrier and
pear in cord blood. Use in pregnancy requires weighing anticipated
nefits against possible hazards, including fetal or neonatal jaundice,
ombocytopenia, other adverse reactions seen in adults. Thiazides
pear and triamterene may appear in breast milk. If their use is essential,
patient should stop nursing. Adequate information on use in children
not available. Sensitivity reactions may occur in patients with or with-
t a history of allergy or bronchial asthma. Possible exacerbation or
tivation of systemic lupus erythematosus has been reported with
azide diuretics.

ecautions: The bioavailability of the hydrochlorothiazide component of
yazide' is about 50% of the bioavailability of the single entity.
eoretically, a patient transferred from the single entities of triamterene
d hydrochlorothiazide may show an increase in blood pressure or fluid
ention. Similarly, it is also possible that the lesser hydrochlorothiazide
oavailability could lead to increased serum potassium levels. However,
tensive clinical experience with 'Dyazide' suggests that these conditions
ve not been commonly observed in clinical practice. Angiotensin-
nverting enzyme (ACE) inhibitors can elevate serum potassium; use
th caution with 'Dyazide'. Do periodic serum electrolyte determinations
articularly important in patients vomiting excessively or receiving
renteral fluids, and during concurrent use with amphotericin B or
rticosteroids or corticotropin [ACTH]). Periodic BUN and serum
eatinine determinations should be made, especially in the elderly,
abetics or those with suspected or confirmed renal insufficiency.
imulative effects of the drug may develop in patients with impaired renal
nction. Thiazides should be used with caution in patients with impaired
patic function. They can precipitate coma in patients with severe liver
sease. Observe regularly for possible blood dyscrasias, liver damage,
her idiosyncratic reactions. Blood dyscrasias have been reported in
tients receiving triamterene, and leukopenia, thrombocytopenia,
ranulocytosis, and aplastic and hemolytic anemia have been reported
th thiazides. Thiazides may cause manifestation of latent diabetes
ellitus. The effects of oral anticoagulants may be decreased when
ed concurrently with hydrochlorothiazide; dosage adjustments may be
cessary. Clinically insignificant reductions in arterial responsiveness
norepinephrine have been reported. Thiazides have also been shown to
crease the paralyzing effect of nondepolarizing muscle relaxants such
tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic
ood studies in cirrhotics with splenomegaly. Antihypertensive effects
ay be enhanced in post-sympathectomy patients. Use cautiously in
irgical patients. Triamterene has been found in renal stones in associa-
on with the other usual calculus components. Therefore, 'Dyazide'
ould be used with caution in patients with histories of stone formation.
few occurrences of acute renal failure have been reported in patients
'Dyazide' when treated with indomethacin. Therefore, caution is
lvised in administering nonsteroidal anti-inflammatory agents with
yazide'. The following may occur: transient elevated BUN or creatinine
both, hyperglycemia and glycosuria (diabetic insulin requirements may
altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia),
creasing alkali reserve with possible metabolic acidosis. 'Dyazide'
terferes with fluorescent measurement of quinidine. Hypokalemia is
common with 'Dyazide', but should it develop, corrective measures
ould be taken such as potassium supplementation or increased dietary
take of potassium-rich foods. Corrective measures should be instituted
autiously and serum potassium levels determined. Discontinue correc-
ve measures and 'Dyazide' should laboratory values reveal elevated
erum potassium. Chloride deficit may occur as well as dilutional
ponatremia. Concurrent use with chlorpropamide may increase the risk
severe hyponatremia. Serum PBI levels may decrease without signs
thyroid disturbance. Calcium excretion is decreased by thiazides.
yazide' should be withdrawn before conducting tests for parathyroid
nction. Thiazides may add to or potentiate the action of other anti-
pertensive drugs. Diuretics reduce renal clearance of lithium and
crease the risk of lithium toxicity

dverse Reactions: Muscle cramps, weakness, dizziness, headache,
ry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other
ermatological conditions; nausea and vomiting, diarrhea, constipation,
ther gastrointestinal disturbances; postural hypotension (may be
ggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis,
aresthesias, icterus, pancreatitis, xanthopsia and respiratory distress
icluding pneumonitis and pulmonary edema, transient blurred vision,
ialadenitis, and vertigo have occurred with thiazides alone. Triamterene
as been found in renal stones in association with other usual calculus
omponents. Rare incidents of acute interstitial nephritis have been
eported. Impotence has been reported in a few patients on 'Dyazide',
lthough a causal relationship has not been established.

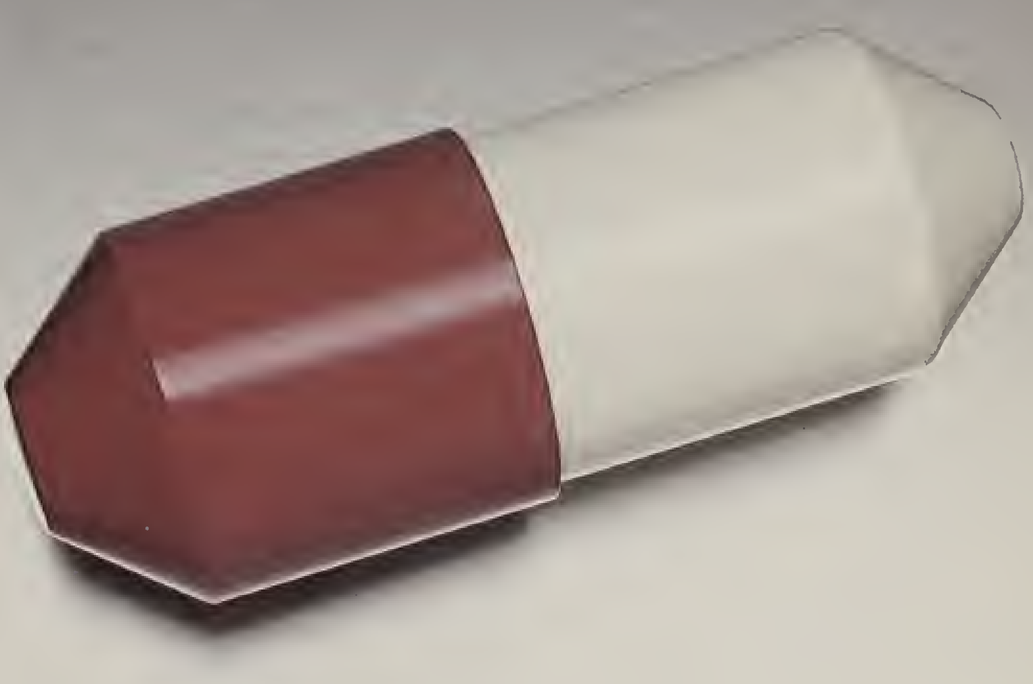
**upplied: 'Dyazide' is supplied as a red and white capsule, in bottles of
000 capsules; Single Unit Packages (unit-dose) of 100 (intended for
istitutional use only); in Patient-Pak™ unit-of-use bottles of 100.**

RS-DZ.L42

In Hypertension*... When You Need to Conserve K+

Remember the Unique Red and White Capsule: Your Assurance of SK&F Quality

Serum K⁺ and BUN should be checked periodically (see Warnings and Precautions).



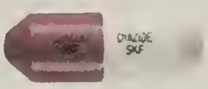
Potassium-Sparing

DYAZIDE®

25 mg Hydrochlorothiazide/**50 mg** Triamterene/SKF

Over 20 Years of Confidence

The unique
red and white
Dyazide® capsule:
Your assurance of
SK&F quality.



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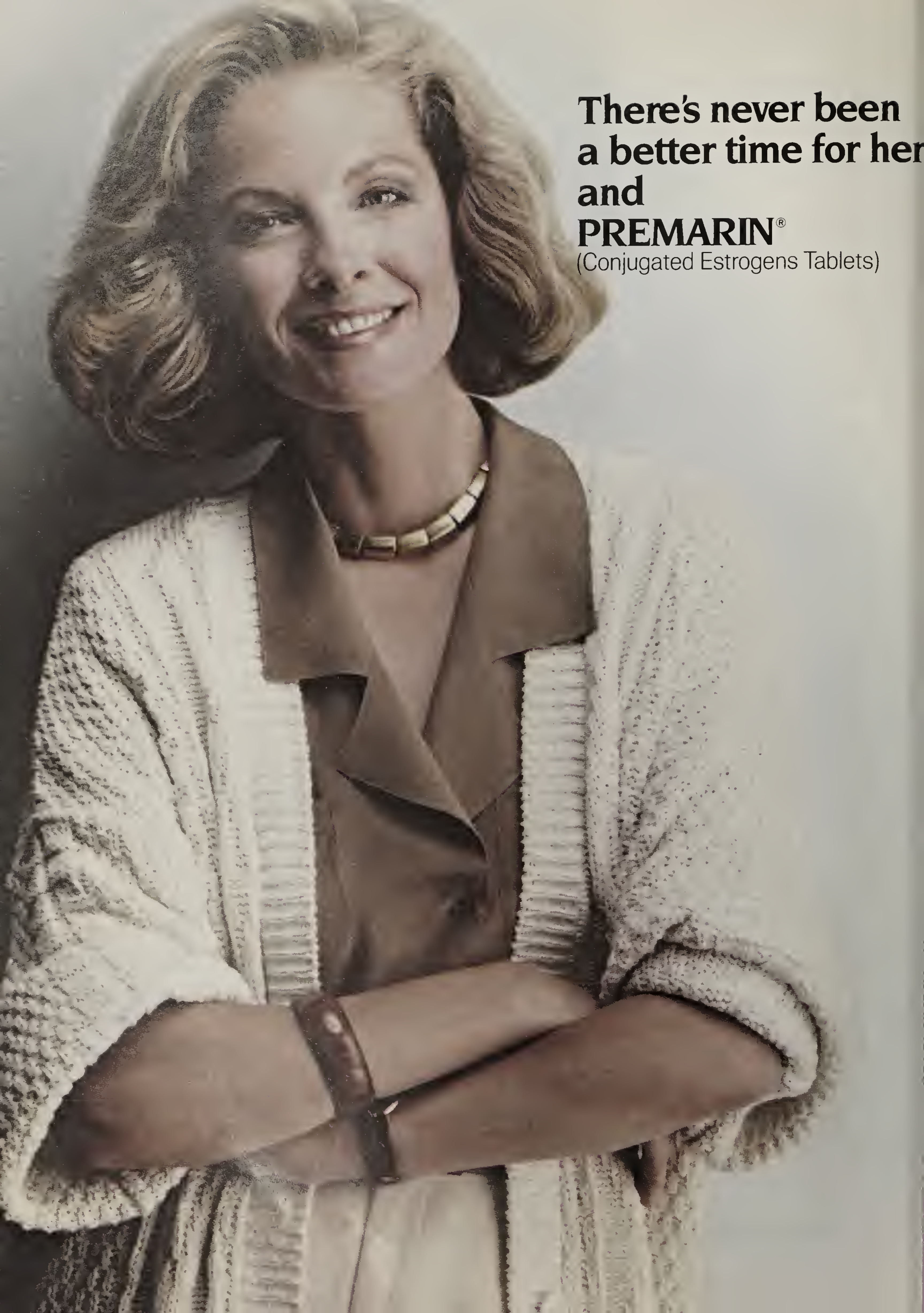


There's never been a better time for her and PREMARIN®

(Conjugated Estrogens Tablets)

Now the evidence looks better than ever

Significantly reduced risk of endometrial hyperplasia

Endometrial hyperplasia was significantly reduced when progestin was added to PREMARIN therapy for more than ten days a month.[1-4] The risk of endometrial hyperplasia may also be reduced through cyclic administration of unopposed, low-dose PREMARIN.

Effect on lipids—an important feature

PREMARIN used alone does not adversely affect lipid levels. In fact, a clinical study has shown a significant increase in HDL cholesterol—from 49.7 mg/dL to 56.4 mg/dL—and decrease in LDL cholesterol—from 165.1 mg/dL to 138.1 mg/dL—after one year of therapy with PREMARIN, 0.625 mg.[5]

Low-dose control of menopausal symptoms*

PREMARIN effectively relieves vasomotor symptoms, such as hot flashes. When estrogen deficiency is limited to atrophic vaginitis, PREMARIN® (conjugated estrogens) Vaginal Cream restores the vaginal environment to its premenopausal state.

The most widely used, most extensively studied estrogen worldwide.

PREMARIN®

(Conjugated Estrogens Tablets)

Most trusted for more reasons

*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

PREMARIN®

(Conjugated Estrogens Tablets)

0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

The appearance of these tablets is a trademark of Ayerst Laboratories.

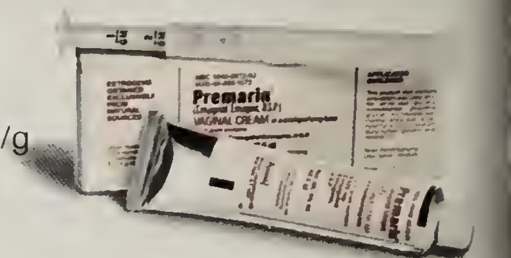
For atrophic vaginitis

PREMARIN®

(Conjugated Estrogens)

Vaginal Cream

0.625mg/g



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement, it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a. Increased sulfobromophthalein retention.

b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d. Impaired glucose tolerance.

e. Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g. Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued, erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically:* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis —0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605 **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985; 67: 496-499. **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

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Ayerst®

AYERST LABORATORIES
New York, NY 10017

T6194/B86

"Living in the city
is lonely enough...
with herpes it's like
solitary confinement."

ZOVIRAX®
(acyclovir)
CAPSULES

Prevent genital herpes recurrences month after month with daily therapy.

(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)

Please see last page of this advertisement for brief summary of prescribing information.

ZOVIRAX®
(acyclovir)
CAPSULES

Help free your patients from recurrences.

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks —month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRA CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/ vomiting, vertigo, and arthralgia.

The physical and emotiona difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

Please see brief summary of prescribing information on next pag

Prevent recurrences month after month*

ZOVIRAX®
(acyclovir)
CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies,. the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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Muneeb U. Haroon, MD —IM
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Taylor 48180

Robert H. Hayashi, MD —OBG
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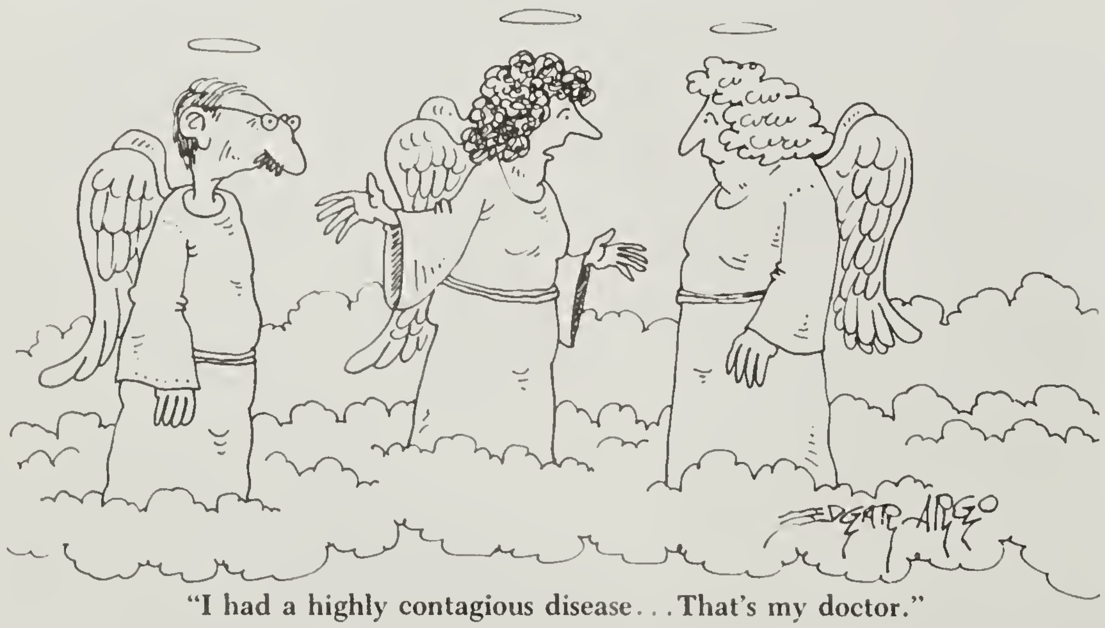
Ann Arbor 48109

Continued on page 102



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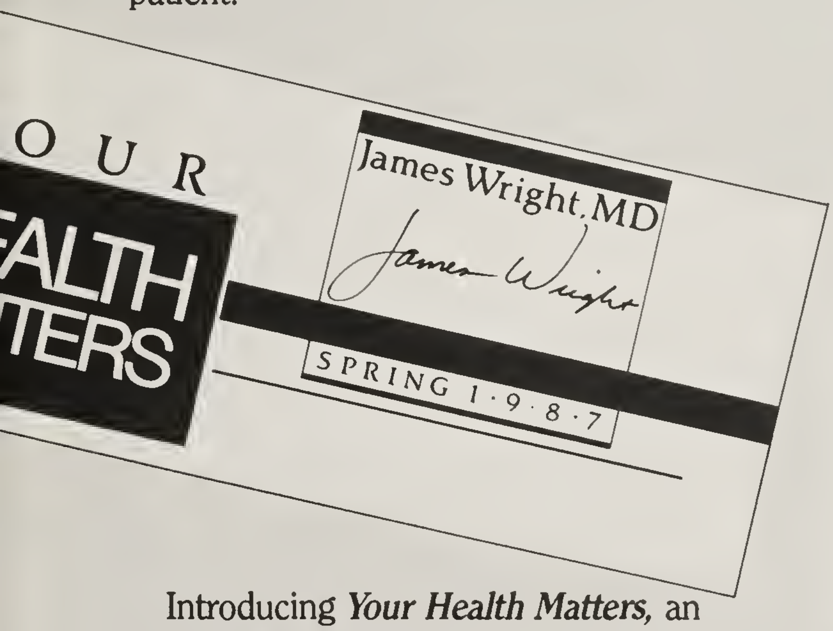

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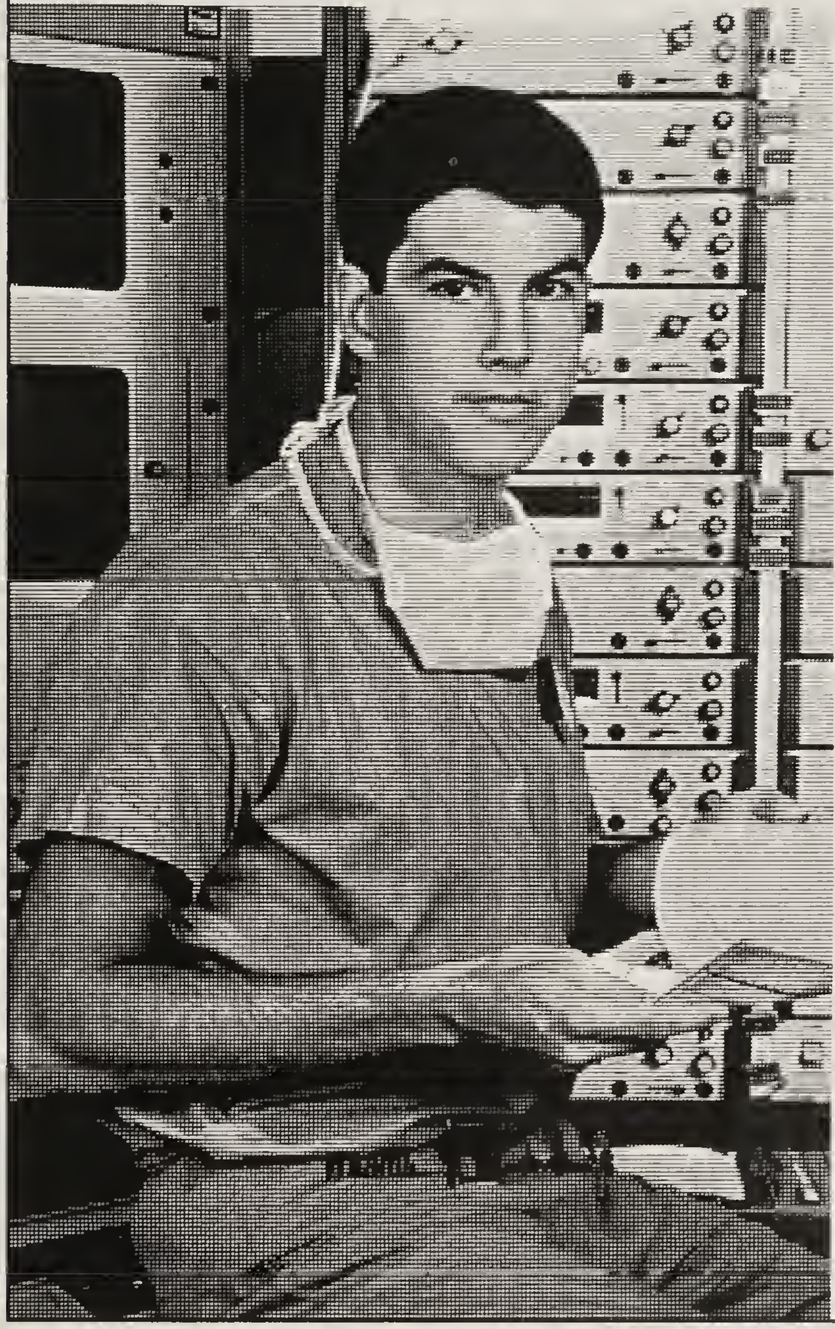

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

Date: March 4, **Stroke: A Multidisciplinary Approach. Location:** Kalamazoo Hilton Inn. **Sponsor:** Borgess Medical Center neurophysiology Department and Southwestern Michigan Area Health Education Center. **Contact:** Bill Daam, Neurophysiology Department, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-4895. **Approved for:** 5.75 hours of Category I Credit.

Date: March 12-14, **Advanced Cardiac Life Support (Provider & Recertification) Course. Location:** Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Life Support Services and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. **Approved for:** Category I Credit: 20 credits for ACLS and 6 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

Date: March 12-17, **Ophthalmology: Basic and Clinical Review Course. Location:** Hotel Pontchartrain, Detroit. **Sponsor:** Kresge Eye Institute of Wayne State University School of Medicine. **Contact:** Division of Continuing Medical Education, Wayne State University School of Medicine, 4H University Health Center, 4201 St. Antoine, Detroit 48201 (313)577-1180. **Approved for:** 42 hours of Category 1 Credit.

Date: March 13-14, **Annual Postgraduate Course in Obstetrics and Gynecology: Challenges and Changes of the 1980s. Location:** Towsley Center, University of Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Gayle Fox, Office of Continuing Medical Education, The University of Michigan, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 12.3 hours of Category I Credit.

Date: March 18, **Dermatology Update. Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital Continuing Medical Education Committee. **Contact:** Carol Mastroianni, Program Coordinator, CME, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: March 24-28, **Family Practice—Eleventh Annual Spring Refresher and Board Examination Review. Location:** Towsley Center, University of Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Georgia Barton, Office of Continuing Medical Education, University of Michigan Medical School, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 33.75 hours of Category I Credit.

Date: March 25-26, **Michigan Conference on Maternal and Perinatal Health. Location:** Hyatt Regency, Dearborn. **Sponsor:** MSMS. **Contact:** Sherry Fent, 120 W. Saginaw, East Lansing 48823 (517)337-1351. **Approved for:** 13 hours of Category I Credit.

Date: March 28, **Emergency Medicine Oral Boards Preparation Workshop. Location:** St. Mary's Hospital, Saginaw. **Sponsor:** St. Mary's Hospital and Michigan State University College of Osteopathic Medicine. **Contact:** Michigan ACEP, 1305 Abbott Road, Suite 104, East Lansing 48823. **Approved for:** 5 hours of Category I Credit.

Date: April 1, **Pulmonary Rehabilitation Symposium. Location:** Fetzer Center, Western Michigan University, Kalamazoo. **Sponsor:** Pulmonary Services, Borgess Medical Center and Southwestern Michigan Area Health Education Center. **Contact:** Judy Smith, Pulmonary Services, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-4875. **Approved for:** 5 hours of Category I Credit.

Date: April 3-5, **Tutorial on Level I Myofascial Release Technique. Location:** Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, MA, Director of Continuing Medical Education, MSU College of Osteopathic Medicine, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 24 hours of Category I Credit.

Date: April 6-9, **Advanced Cardiac Life Support Provider Course.** (April 6 and 8 Recertification Course—8 Category I Credits—4 for BCLS and 4 for ACLS). **Location:** Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Center—Staff and Patient Education Department. **Contact:** Claire A. Zieman, Staff and Patient Education, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-8320. **Approved for:** 25 Credits, 4 for BCLS and 21 for ACLS.

Date: April 6-10, **Tenth Annual Spring Workshop, Head and Neck Oncology Course. Location:** Towsley Center for Continuing Medical Education, University of Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Jolene Glaspie (313)763-1400. **Approved for:** 43.5 hours of Category 1 Credit.

Date: April 10, **Flexible Sigmoidoscopy Conference. Location:** Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Charles L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 5.5 hours of Category I Credit.

Date: May 1, **11th Annual Preventive Cardiovascular Medicine and Rehabilitation Symposium. Location:** John E. Fetzer Business Development Center—Kirsch Auditorium, Western Michigan University, Kalamazoo. **Sponsor:** Borgess Medical Center—Institute for Cardiovascular Health, Southwestern Michigan Area Health Education Center, American College of Sports Medicine and American Heart Association. **Contact:** Jeff Morgan, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 5 hours of Category 1 Credit.

Date: May 7-9, **Medicolegal Investigation of Death. Location:** Hotel Pontchartrain Detroit. **Sponsor:** Wayne State University School of Medicine Department of Pathology Wayne County Medical Examiner's office with the cooperation of the Criminal Defense Attorneys of Michigan. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4-H University Health Center, 4201 St. Antoine, Detroit 48201, (313)577-1180. **Approved for:** 15.5 hours of Category I Credit.

Date: May 14, **Sexually Transmitted Diseases—1987. Location:** Fetzer Business Development Center, Western Michigan Univer

Continued on page 110

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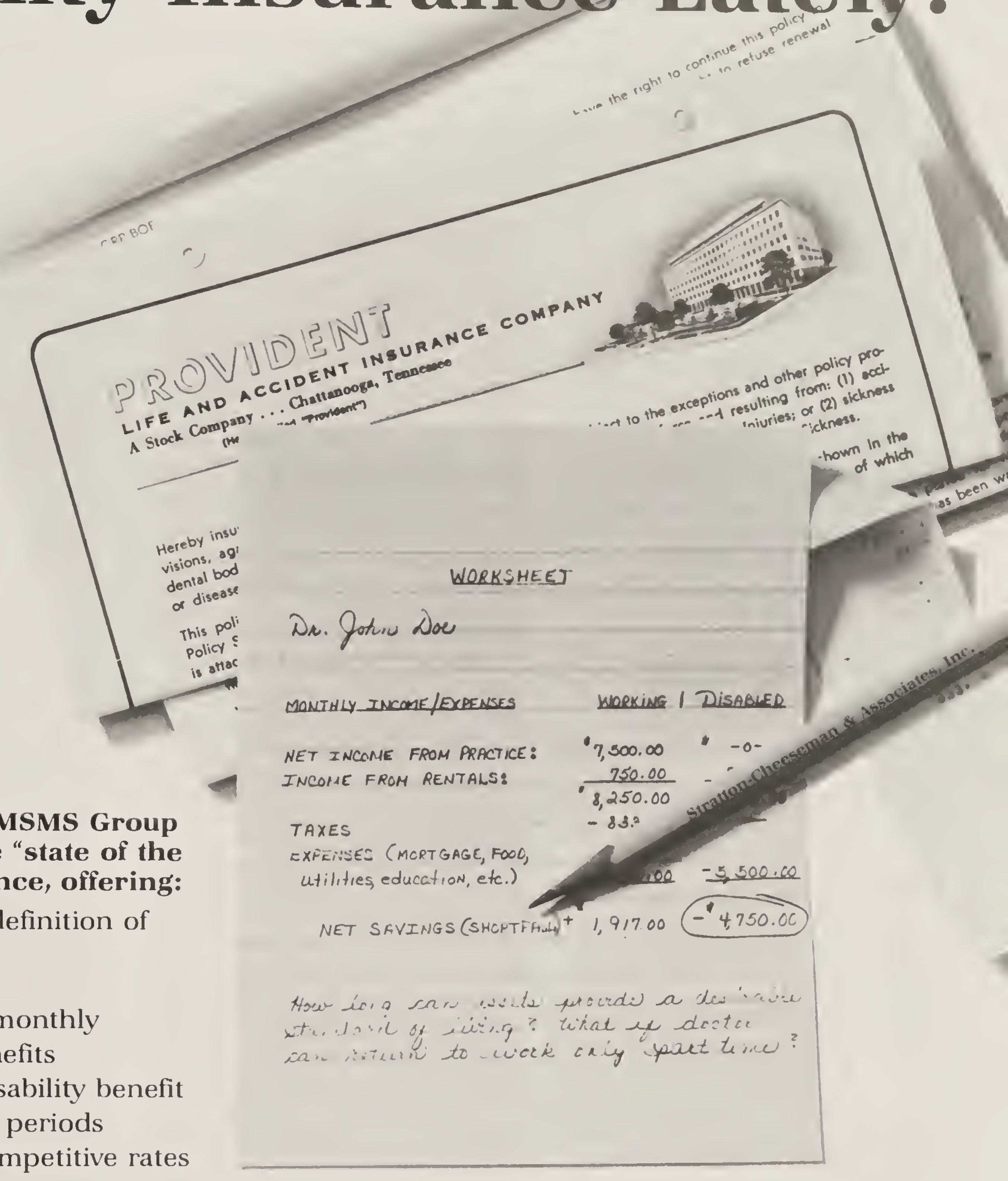

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CATEGORY I/Continued

sity, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Charles L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 6 hours of Category I Credit.

Date: May 14, **Perinatal Periscope—A look to the future. Location:** Bernhard Student Center, Western Michiagn University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association, Southwestern Michigan Area Health Education Center and the American Academy of Family Physicians. **Contact:** Wendy Finsterwald, Southwestern Michigan Perinatal Association, 252 East Lovell Street, Kalamazoo 49007 (616)383-4669. **Approved for:** 6 hours of Category I Credit.

Date: May 15-17, **Advanced Cardiac Life Support (Provider & Recertification) Course. Location:** Gilmore Center of Health Education Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Life Support Services and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. **Approved for:** Category I Credit: 20 credits for ACLS and 6 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

Date: May 15-17, **The Differential Diagnosis of Musculoskeletal Pain: Emphasis on the Low Back. Location:** Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU College of Osteopathic Medicine, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 20 hours of Category I Credit.

Date: May 20, **Current Update in the Treatment of Breast Carcinoma. Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital Continuing Medical Education Committee. **Contact:** Carol Mastroianni, Program Coordinator, CME, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313)343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 27-31, **Tutorial on Level II Manual Medicine Techniques (Below Diaphragm). Location:** Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU College of Osteopathic Medicine, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

Date: June 4-5, **13th Annual Kalamazoo Symposium for Michigan Neonatologists and Neonatal Fellows. Location:** Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Neonatology Services of the Pediatric Section, Bronson Methodist Hospital and Mead Johnson Laboratories. **Contact:** John V. Hartline, MD, Neonatology Services of the Pediatric Section, Bronson Methodist Hospital, 252 East Lovell, Kalamazoo 49007. **Approved for:** 7.25 hours of Category I Credit.

Date: August 31-September 3, **Advanced Cardiac Life Support Provider Course. (August 31 and September 2 Recertification Course—8 Category I Credits—4 for BCLS and 4 for ACLS). Location:** Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Center—Staff and Patient Education Department. **Contact:** Claire A. Zieman, Staff and Patient Education, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-8320. **Approved for:** 25 Credits (4 for BCLS and 21 for ACLS).

Date: September 10-12, **Advanced Cardiac Life Support (Provider & Recertification) Course. Location:** Gilmore Center of Health Education Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Life Support Services and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. **Approved for:** Category I Credit: 20 credits for ACLS and 4 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

Date: November 5-7, **Advanced Cardiac Life Support (Provider & Recertification) Course. Location:** Gilmore Center of Health Education Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Life Support Services and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. **Approved for:** Category I Credit: 20 credits for ACLS and 6 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

MSMS, MSMS/A, AMA & MEDICAL ASSISTANTS

February 25-27 — AMA conference: Medical Profession: Enduring Values and New Challenges, Los Angeles, contact: Pat Clark (312)645-4497.

March 18 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

March 21 — MSMS Hospital Medical Staff Section Annual Meeting, Hyatt Regency, Dearborn, contact: Thomas White, MSMS Headquarters, (517)337-1351.

April 24-25 — MSMS House of Delegates, Amway Grand Plaza, Grand Rapids, contact: William Madigan (517)337-1351.

April 25-26 — DNA Probes in the Practice of Medicine, Hyatt Regency Washington Hotel on Capitol Hill, contact: R. Mark Evans, PhD, Office of Biotechnonogy, AMA, 535 North Dearborn, Chicago 60610, (312) 645-4567.

May 7-8 — AMA National Conference on AIDS, Marriott Hotel, Chicago, contact: Pat Clark, AMA (312)645-4497.

July 16-19 — MSMS Board of Directors Midsummer Meeting, Deer Lake, Boyne Mountain, contact: William Madigan (517)337-1351.

September 23 — MSMS Board of Directors Meeting, MSMS Headquarters, East Lansing, contact: William Madigan (517)337-1351.

November 18 — MSMS Board of Directors Meeting, MSMS Headquarters, contact: William Madigan (517)337-1351.

OTHER MEETINGS

March 5 — Michigan Radiological Society Annual Hickey Memorial Lecture, Detroit Athletic Club, contact: Dianne Hansen, Administrative Secretary, Michigan Radiological Society, 1010 Antietam, Detroit 48207, (313)567-1640.

March 5 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, Lansing, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313)243-7144.

April 2 — Michigan Radiological Society "Cross Sectional Imaging of the Female Pelvis—MRI, CT, Ultrasound," University of Michigan, contact: Dianne Hansen, Administrative Secretary, Michigan Radiological Society, 1010 Antietam, Detroit 48207, (313)567-1640.

April 3 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313)243-7144.

May 1 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313)243-7144.

May 4-5 — Michigan Association for Infant Mental Health 11th Annual Conference—Infants and Families in Poverty, University of Michigan, contact: U-M Extension Service, Conferences and Institutes, 200 Hill Street, Ann Arbor 48104 (313) 764-5304.

May 7 — Michigan Radiological Society Annual Meeting, 1010 Antietam, Detroit, contact: Dianne Hansen, Administrative Secretary, 1010 Antietam, Detroit 48207 (313)567-1640.

June 5 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313)243-7144.

July 10-11 — Michigan Society of Thoracic Surgeons Annual Meeting, Traverse Resort Village, contact: Rodman E. Taber, MD, Michigan Society of Thoracic Surgeons, Wayne County Medical Society Building, 1010 Antietam Road, Detroit 48207 (313)567-1640.

July 10 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313)243-7144.

August 18-21 — Michigan Health Officers Association, Annual General Membership Meeting, Grand Traverse Resort, Traverse City, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313)243-7144.

September 4 — Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, President, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161, (313)243-7144.

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 40¢ per word, with a minimum charge of $20.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

GENERAL SURGERY PRACTICE FOR SALE, Farmington Hills Location. All furniture and fixtures, computer and medical equipment. Loyal referral base. Lease assignable/renegotiable. Staff is willing to stay at this desirable location. Call or write: MICHIGAN PRACTICE BROKERAGE CORPORATION, 20300 Civic Center Drive, Suite 230, Southfield 48076-4105 or (313)357-1663.

FAMILY PRACTITIONER OR INTERNIST willing to do Family Practice needed. If interested contact: Caro Family Physicians, 206 Montague, Caro 48723. Phone (517)673-2105.

FAMILY PRACTITIONER. Marshfield Clinic-Colby Center is seeking a Board certified/Board eligible Family Practitioner to join another Family Practitioner in an established office based group practice in Colby, Wisconsin. The Colby Center offers the Family Practitioner the autonomy of private, primary care practice, plus financial and professional resources of Marshfield Clinic, a 250 physician multispecialty group. This physician would enjoy full hospital privileges but without the distractions of OB or surgical responsibilities. Excellent salary and benefits. Please send curriculum vitae to Robert Peterson, Director, Regional Services, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449 or call collect at (715)387-5498.

NORTHWESTERN LOWER PENINSULA—Attractive full and part time emergency department positions available in various locations. Malpractice insurance provided. Contact Emergency Consultants, Inc., One Windemere Place, Room 23, Petoskey 49770, 1-800-253-7092 or in Michigan 1-800-632-9650.

MONROE, MICHIGAN—Seeking full time emergency department physician for 193 bed hospital located 30 miles south of Detroit. Approximately 23,000 patients seen annually. Must be Board eligible or Board certified in primary specialty or emergency medicine. Excellent compensation and malpractice insurance provided. Contact Emergency Consultants, Inc., One Windemere Place, Room 23, Petoskey 49770, 1-800-253-7092 or in Michigan 1-800-632-9650.

UPPER PENINSULA, WESTERN—Seeking full time emergency department physician for low volume facility. Attractive weekday schedule. Contact Emergency Consultants, Inc., One Windemere Place, Room 23, Petoskey 49770, 1-800-253-7092 or in Michigan 1-800-632-9650.

URGENT AND PRIMARY CARE FACILITIES across the State of Michigan are looking for physicians with interest and experience in primary care, urgent care, internal medicine, worker compensation and emergency fields to fill part time and full time positions. Contact Yvonne Alles by sending CV to Michigan Chapter of NAFAC, 21 Michigan NE, Suite 370, Grand Rapids 49503

EXCELLENT OPPORTUNITIES FOR—Otorhinolaryngologist, Obstetrician/Gynecologist, Psychiatrist, Endocrinologist, Radiologist, Orthopedist, Dermatologist and General/Family Practitioner. Excellent opportunity for physicians in Los Angeles suburb to join 80 member multispecialty medical group. Large fee-for-service and prepaid practice, no Medi-Cal. Excellent compensation program based on guarantee plus incentive, profit sharing and pension plan. Group provides health, dental, life and malpractice. Partnership in real estate and medical corporation available. See our Display Ad in this publication. Send CV to Wm. Shaw, Associate Administrator, Mullikin Medical Center, 17821 S. Pioneer Blvd., Artesia, CA 90701.

BE A "WINTER TEXAN" INTERNIST. Enjoy the warm, beautiful Rio Grande Valley while practicing internal medicine with an internist. Texas license essential. Salary, living accommodations and malpractice insurance. Send curriculum vitae: 104 South Bryan Road, Mission, Texas 78572 or contact (512)585-2783 for more information.

OB/GYN Catherine McAuley Health Center, a progressive multi-hospital health care corporation with a strong obstetrical service and teaching program, seeks to establish a new OB/GYN group practice. Guaranteed income through a subsidized practice arrangement or competitive salary/fringe benefits package. Must be board eligible or board certified. Starting date is negotiable—prefer 7/1/87 or earlier. For further information contact: F. W. Jeffries, MD, Department Chairman, Obstetrics/Gynecology, Catherine McAuley Health Center, 5301 East Huron River Drive, PO Box 992, Ann Arbor 48106.

FAMILY PRACTICE IN KALAMAZOO: Fifth full-time physician needed for a dynamic family practice (2 sites) with full salary and fringes and leisure-time assured by part time physician/physician assistant's coverage of evening and industrial medicine services. Contact Doctor Harrell, 117 W. Paterson, Kalamazoo 49007 or phone (616)349-8725.

OCCUPATIONAL MEDICINE IN KALAMAZOO: Growing occupational medicine practice (associated with a dynamic 4 physician family practice) seeking second full time physician for salaried position. Contact Doctor Harrell, Kalamazoo Occupational Medicine, 2597 Sprinkle Road, Kalamazoo 49001 or phone (616)345-8638.

SOLO INTERNIST SEEKS GENERAL INTERNIST to share in rapidly growing, fee-for-service practice. Subspecialty interest welcome. Well equipped office. 100-bed modern hospital excellent working and living environment. Call or write Robert Shannon, MD, 218 South James Street, Ludington 49431 (616)843-2525.

NEAR ANN ARBOR—PSYCHIATRISTS Two full time positions available to work with adult inpatient population. Excellent fringe benefits provided through Michigan Civil Service. Excellent schools and university in Ann Arbor area. Salary $65,250 to $86,484 depending on experience. For information contact Donald J. Proux, MD (313)481-2821 or Patricia Clark (313)481-2696 or 481-2687, Ypsilanti Regional Psychiatric Hospital, Box A, Ypsilanti 48197. Michigan license required. Equal opportunity employer.

GENERAL INTERNIST Marshfield Clinic, one of the nation's largest multispecialty private groups, is seeking several Board certified/Board eligible General Internal Medicine specialists to join its expanding 18 member section. Internal Medicine Residency Program, University affiliation, Research Foundation, and large regional referral base contributes to a very stimulating environment. Unique big city medicine opportunity in a family oriented rural setting. Please send curriculum vitae to: John P. Folz, Director, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449 or call collect at (715)387-5181.

EMERGENCY MEDICINE FOR EMERGENCY PHYSICIAN who possesses excellent clinical and trauma skills within a group of 7 Emergency Room Physicians—located in a beautiful northwest Wisconsin area. Position opening July, 1987. Please sent CV to: M. Jaghlit, MD, 900 W. Clairemont Avenue, Eau Claire, WI 54701 or call (715)839-4404.

FULL TIME, PART TIME AND LOCUM TENENS GPs, PPs and Emergency Physicians needed to staff a network of convenience medical care centers located in Bay City, Saginaw, Midland and Mt. Pleasant, Michigan. Flexible hours and attractive compensation packages. Send CV to, or contact Contemporary Medical Management, 503 N. Euclid, Suite 4, Bay City 48796 (517)667-0672.

PEDIATRICS-IMMEDIATE OPENING available for general or subspecialty oriented pediatrician in large hospital based general pediatric group. Attractive southwest Michigan, university community with ample cultural and recreational opportunities. Send CV to Box 99, Michigan Medicine, 120 W. Saginaw, PO Box 950, East Lansing 48823.

GENERAL SURGEON/COLO-RECTAL MD or DO for busy, outpatient proctology/general surgery practice. Excellent opportunity for future independence and freedom. Franchise concept. Must explore. Send resume to: Hemorrhoid Clinics of America, 22000 Greenfield Road, Oak Park 48237, or call (313)967-4140.

GREEN BAY, WISCONSIN 27 physician multispecialty group seeking BC/BE physicians in the following specialties: Family Practice, Ophthalmology, ENT, Dermatology, Plastic Surgery, Radiology, OB/GYN, Internal Medicine and Pediatrics. Green Bay is a progressive community with an easy lifestyle, ample outdoor activities, excellent schools and cultural activities. The Clinic offers competitive salary and excellent fringe benefits. Interested physicians please contact: W. J. Mommaerts, Administrator, West Side Clinic, sc, 1551 Douslman Street, Green Bay, WI 54303.

IMMEDIATE OPENING: One Staff Psychiatrist and one General Practitioner at 250-bed acute treatment psychiatric hospital, JCAH approved, affiliated with University of Iowa Medical College. Forty-hour work week. No night or weekend on call. Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $73,445.00. State law protects employees against malpractice. State pension plan

Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect B. J. Dave, MD, Superintendent, Mental Health Institute, Independence, Iowa 50644. Telephone: (319)334-2583. An equal opportunity employer.

FAMILY PRACTITIONERS, GENERAL PRACTITIONERS or Emergency Medicine Physicians with practice experience wanted for free-standing urgent care centers located in the Central Michigan area. Excellent access to recreational areas. Associate and Medical Director opening immediately. Salary negotiable plus fringe benefits. Send CV to Contemporary Medical Management, Incorporated, 401 South Euclid Avenue, Bay City 48706 (517)6670494.

ARIZONA BASED PHYSICIAN RECRUITMENT firm has opportunities coast to coast. "Professionals working with Professionals." Over 13 years experience. Call (602)795-7474; or send CV to: Mitchell & Associates, Inc., 2761 N. Country Club Road, Suite 202, Tucson, AZ 85716.

EMERGENCY ROOM PHYSICIANS—full or part time positions. Rural Southwest Michigan. Competitive reimbursement; ACLS required; ATLS preferred. Nice rural community. Please send CV to President, SMES, 4341 S. Westnedge, Suite 1112, Kalamazoo 49008.

FAMILY PRACTITIONER AND INTERNAL MEDICINE SPECIALISTS to join seven doctor Family Practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well equipped 77 bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

MISCELLANEOUS

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PLACEMENT SERVICE! We offer a placement service to aid medical professionals seeking associates, employees, partners, or employment. Contact Richard Courey by sending a resume to: Medical Dental Management Consultants, 31158 Perrys Crossing, Farmington Hills 48018 or by phone (313)661-0888.

DISCOVER A PHYSICIAN PLACEMENT SERVICE that puts your needs first! Current openings include FP, ER, Surgical, OB/GYN, PEDS, IM and others. Specialists in the desirable sunbelt. No fees, interview or relocation costs! Send CV to: Department M, Hunter, Holland and Ward, Inc., PO Box 17268, Raleigh, NC 27609 (919)876-5005.

FOR LEASE—SOUTHEASTERN MICHIGAN Medical Suite ground floor, 1,500 square feet, 5 examining rooms, laboratory and office. Building 7 years old. 1770 Highway M-15 Ortonville, between Flint and Pontiac. Can be seen 7 days a week. Key at Kincaids Family Restaurant, 1764 M-15 or call (616)754-4422 for details.

FOR SALE: 4000 S/LC; Real Time/Linear/Cardia Scanner; 2D and M-Mode Cardiac; also Pelvic and Abdominal Ultrasound. Call (517)783-2691.

FEES/Continued

capsule, sutured the laceration, cleaned the avulsed area (medically excellent). The bill itemized each procedure and the total came to $3,800.

I'm asking each of you to look in the mirror. Make your fees fair and not what the traffic will bear. We are a learned profession. Most of us are dedicated to our patients. We work long hours and are respected in the community. We deserve and enjoy good incomes but we cannot "rip-off" society without an eventual backlash. ☐

MALPRACTICE LIABILITY PROTECTION. Stop judgment creditors from seizing your pension, profit sharing or personal assets in satisfaction of malpractice judgments exceeding insurance limits by taking preventiative action now. Contact Harold Stern, Attorney-at-Law, (313)353-0066

900 TO 1700 SQ. FT. SUITE or suites available soon to lease in prime Pontiac, Waterford location on Elizabeth Lake Road near M-59 at a 4-way stop intersection. Very competitive rent. Chance for medical or dental practice to design own suite from scratch to fulfill your particular needs. Very busy practice already located in this 4300 sq. ft. medical village concept which will expand to around 12,000 sq. ft. in near future. Call (313)681-4470 days or (313)681-4470 evenings to set up meeting or discuss!

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ANESTHESIOLOGIST SEEKING PERMANENT POSITION in Detroit Metro area or locum tenens assignments in Michigan. Board Certified, American born and trained. Ambulatory surgicenter experience. Contact: Sharon M. Schafer, MD, 5741 Folkstone, Troy 48098 (313)879-6246.

Be professional with your fees

By Thomas R. Berglund, MD

Thomas R. Berglund, MD

The other night at a dinner party several of us got into a discussion about professionalism. After much debate we looked it up in *Webster's Dictionary* and the definition is, "a vocation or occupation requiring advanced training in some liberal art or science especially medicine, law, or theology (formerly called the learned professions)."

I am very proud of our profession. The United States has the best medical care in the world. Our hospitals are the finest, and we physicians are the best educated and receive more training than physicians in any other country. As your president, I am the spokesman for the medical profession and receive complaints from other members of the profession as well as the general public. In addition, I deal with the news media and the government.

In previous columns I have exhorted you to help me and all the other MSMS leaders in our dealings with the legislature, third party payors and other agencies by becoming active both politically and by working for organized medicine. Today I ask all of you to help preserve our profession. We are being attacked on all sides by many detractors all in the name of more cost effective medical care. Most of us have responded and have modified our behavior. We admit patients for same-day surgery and do much more outpatient surgery. No longer do we admit patients to hospitals for "workups." Prudent discharge coordination has helped decrease length of hospital stays, and we are utilizing much more home care as well.

Extraordinary charges

A continuing area of concern to me is the abuse of fee charging by some physicians. I am referring to both the extraordinary charges for some procedures and the "insurancemanship" games that take place. I have seen charges for both a hand and a wrist X-ray when one picture was taken, a full charge for a D&C prior to a hysterectomy and a cardiac catheterization billed as a multiple procedure. These abuses have not gone unnoticed. At the AMA Leadership conference two years ago, former HEW Secretary Joseph Califano, who is a member of the Board of Directors of Chrysler Corporation, detailed the cost of cataract surgery to Chrysler. Through the use of computer technology, businesses are getting more sophisticated in tracking costs and are able to spot aberrant charges.

The "system" was exploited so badly by physicians over-billing for laboratory procedures that the legislature passed a bill regulating in-office labs. The same will happen in other areas if we don't correct the problems. The late Dave Siegel, MD, who was MSMS Speaker of the House, told me once that anyone with a flexible tube with a light on the end thought he had a pipeline to Fort Knox.

A privilege, not a right

I know that malpractice costs are high, that we carry heavy life and death decisions on our shoulders, and that after years of schooling and training we deserve a good income. But also remember that our license to practice medicine in Michigan is a privilege and not a right. It is not a privilege to steal.

My frustration reached its peak last week when a young patient who had been involved in an automobile accident brought me a copy of his doctor's bill (I was glad it was from another state). He had banged up his left knee joint, sustained a laceration below the knee and avulsed some skin. The orthopedic surgeon did an arthroscopy, repaired the knee

Continued on page 113

MICHIGAN MEDICINE

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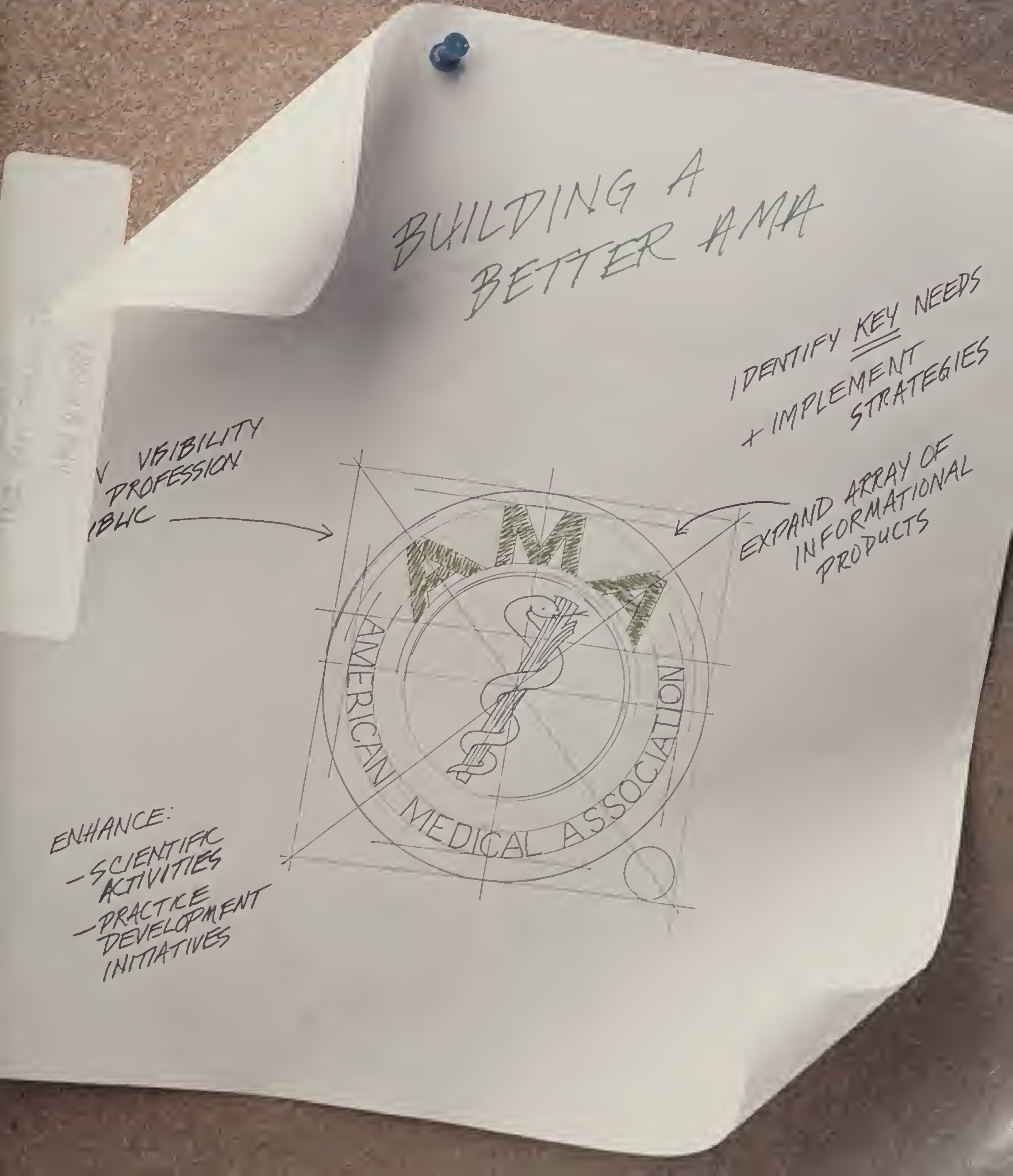
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MICHIGAN MEDICINE

MARCH 1987 VOL. 86 NO. 3

Special Report

The American Medical Association is undergoing an evolution by design — you could say it is a work in progress. Our Special Report features a summary of the AMA's new initiatives for 1987, and a message from President John Coury, MD, about the bottom line: preserving quality health care. The head of Michigan's AMA delegation, Frank B. Walker, MD, explains the workings and goals of the MSMS team, and a roster introduces the players. And MSMS Membership Recruitment and Retention Chairman Cathy O. Blight, MD, analyzes the concept of unified membership. 118

Features

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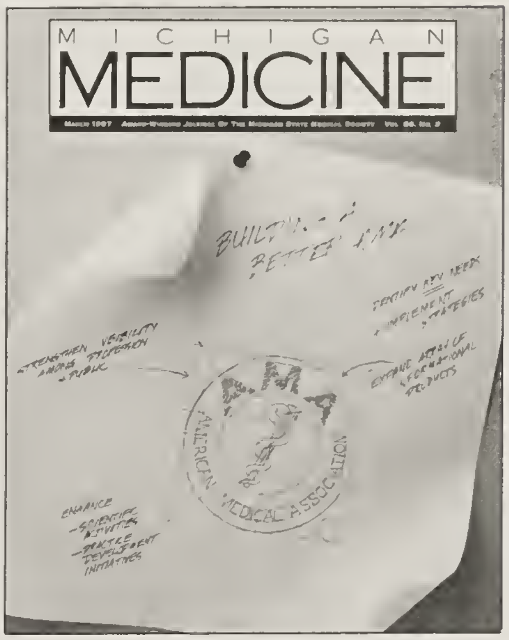

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Cover photo by Kim Kauffman.
Illustration by Hudson Creative Group.

IN MY OPINION

If you can find a better organization. . .

By John W. Hall, MD

Doctor Hall

Doctor Hall, Petoskey urologist, is a member, MSMS Board of Directors and chairman, MSMS Committee on Publications.

In keeping with this month's subject of the AMA, it seemed to be appropriate to write this column on unified membership. Yet, as I tried to do so, I found that I kept arguing with myself. On one hand, unified membership seems so logical. How could anyone expect organized medicine to have any hope of success in addressing the problems of the 1980s without the support of every physician? And yet, it is just as ridiculous to force membership on anyone.

Early in my career, I didn't belong to the AMA. The distance from northern Michigan to Washington and the tremendous scope of our national problems discouraged my involvement. My only contact with the AMA seemed to be a stream of form letters soliciting group life insurance. So, I joined the locker room criticism of the AMA's efforts. I hoped that the problems would go away and leave me alone.

Obviously, the problems persisted. And, I, with a little more maturity, realized that if I wanted to responsibly criticize efforts of my fellow physicians, then I would first have to become involved enough to know the organization and the individuals involved. I could then evaluate the AMA and make an enlightened choice about membership.

It is easy to evaluate our local and state societies. We can have a hands-on experience with their programs and benefits. We can meet the elected officers and representatives personally. It is ob-

Continued on facing page

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Have doctors forgotten?

After the malpractice crises in the 1930s we forgot. After the crisis in 1970, we forgot. After the crisis in 1985, we forgot.

It seems strange that one year ago the doctors' room was full of discussion: What can we do to solve malpractice? Now alas, for the last two or three months I have heard little or no comments by the doctors. Apparently they have finally collected enough money to pay the increased premiums, and so, let the matter slide.

We should know better. There are more suits now than ever. I'm sure this spring and summer there will have to be another large increase in the cost of malpractice insurance.

Last year the doctors of Michigan made a mighty effort to get the public and the legislature to pass some legislation to help ease the liability crisis. The few bills that were passed did nothing to help ease the medical liability crisis.

I reiterate my oft repeated statement: "Doctors cannot collect enough money to satisfy the public and the lawyers." I believe the doctors would not be afraid of malpractice suits if they were protected from catastrophic rewards that would take away the doctors' lifetime savings.

This brings back my contention that all who carry liability insurance should advocate that the federal and state governments should establish Liability Compensation Commissions.

These commissions might be patterned after the Workers' Compensation Commission. Let the Liability Compensation Commission handle all the liability cases. Let the commission collect and dispense the money according to the rules that they set up.

This would get the physicians, dentists, bar owners—even the lawyers— out of the responsibility of being collectors for malpractice liability cases.

Please do not forget! Our crisis is still here and we should be working to help solve it.

Hira E. Branch, MD
Flint

OPINION/Continued

viously more difficult to have direct contact on the national level. But we have AMA delegates and alternates as well as many other physicians who serve on AMA committees. Write or call them with your problems or proposals! Let your district director or the MSMS staff help you with this contact.

Evaluate carefully

As professionals, we are solicited by many organizations. The causes are legion but our resources are limited. We have to evaluate each proposal carefully to get the biggest bang for our buck.

It is no different with organized medicine. We must continually grade the performance of all of the representatives. Do they seem knowledgeable regarding regional and national issues? How do they go about addressing these problems? Are they tenacious and persistent in the political arena? Are they innovative in finding new solutions to a stalemate? And the AMA itself—read its literature. Study its newsletters. Does it offer quality CME programs? Can you receive a better benefit package elsewhere? Does it offer the best forum for addressing socioeconomic problems? Does any medical organization command more respect in Washington?

Finally, you can make an educated decision regarding AMA membership. You have involvement and first-hand knowledge of the issues. You have evaluated the programs and the individuals. You have made your own contribution of time and effort.

And so, to paraphrase Lee Iacocca, if you can find a better organization—join it. Otherwise, voluntarily join your fellow physicians in the AMA because the problems won't go away without your help. ☐

Michigan physicians have a strong AMA team

By Frank B. Walker, MD

On the political front, Michigan has been very fortunate regarding the number of its physicians who have been elected or appointed to various AMA positions.

Doctor Walker

As the chairman of the MSMS delegation to the American Medical Association, I have been asked to reflect and comment upon some of the issues of concern to Michigan physicians and to the AMA House of Delegates.

First, however, I feel brief explanations of the organization and workings of the Michigan delegation to the AMA are in order. The AMA House of Delegates is composed of 392 delegates and a like number of alternates representing state medical associations on a basis of one delegate and alternate per 1,000 AMA members; 69 delegates representing national medical specialty societies on a basis of one per specialty society; and 10 section and service delegates representing medical students, medical schools, resident physicians, hospital medical staffs, young physicians, the Army, Navy, Air Force, public health service and Veterans Administration.

The Michigan "official AMA family" currently includes 11 delegates and 11 alternates elected by the MSMS House of Delegates, six delegates/alternates elected or appointed by their national medical specialty societies, and delegates to the various AMA sections enumerated above.

This group of about 35 physicians and MSMS staff members meets prior to and during the summer annual and winter interim meetings of the AMA House of Delegates. At caucuses (usually at 6:30 am daily during the meeting) reports and resolutions to come before the reference committees and the House are fully discussed, and positions of support, neutrality or opposition are agreed upon. Each delegate or alternate is assigned to one of the nine House reference committees and expresses the delegation opinion on the various issues. The delegation's caucus after receipt of the reference committee report results in the Michigan position when issues come to a vote at the general session of the House. As the House of Delegates vote represents the official policy of the American Medical Association on a given matter, the participation of each and every member of the Michigan delegation is vital.

The Michigan delegation elects its officers at the annual AMA meeting in Chicago. Last June, Richard McMurray, MD, Flint, was elected by the AMA House of Delegates to the AMA Council on Ethical and Judicial Affairs. This position constitutionally does not permit any other AMA duties, and Doctor McMurray was required to resign as an AMA delegate and as chairman of the Michigan delegation. He had held this position for a number of years and had devoted many hours of hard work and dedicated service to the physicians of Michigan, and we thank Dick for it. In the election that followed, yours truly was elected chairman, Robert Burton, MD, Grand Rapids, vice-chairman and Richard Gascoigne, MD, Adrian, treasurer.

Two committees

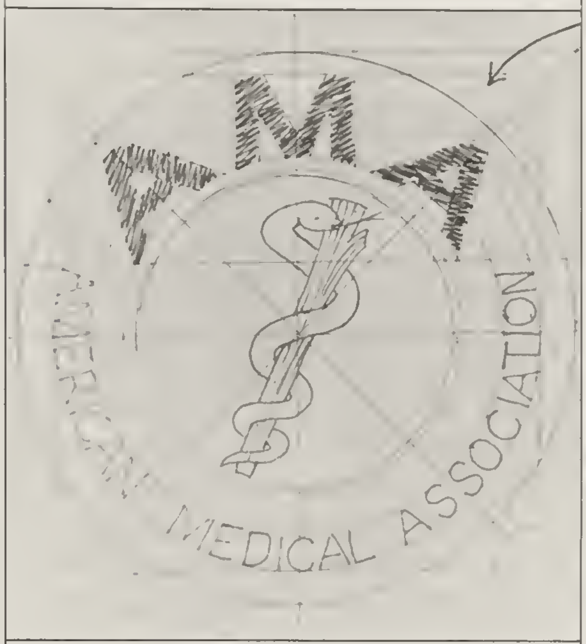
Although all members of the Michigan AMA delegation are expected to be active participants in all Michigan and AMA activities, for purposes of organization and response time, there are two delegation committees. The "political" committee, chaired by Thomas Berglund, MD, Portage,

The author, Doctor Walker, Grosse Pointe Farms, is chairman, Michigan Delegation to the American Medical Association.

ascertains interests of the Michigan delegation regarding appointive or elective council/board/officer positions; Michigan assignments and representation at the Great Lakes candidate caucuses; and promotion of Michigan candidates for appointive/elective AMA positions. Gerald Mandell, MD, Detroit, chairs the "issues" committee, which solicits, writes and edits resolutions to be introduced into the AMA House of Delegates at the request of the MSMS House of Delegates, the Michigan AMA delegation or other individuals.

On the political front, Michigan has been very fortunate regarding the number of its physicians who have been elected or appointed to various AMA positions. John Coury, MD, Port Huron, first as a member of the AMA Board of Trustees and then as President-elect and President, has been most supportive in the effort to nominate, elect, and/or appoint individuals recommended by the MSMS Board of Directors or the various specialty societies.

Currently, in addition to Doctors Coury and McMurray (Council on Ethical and Judicial Affairs), Michigan is represented on various AMA bodies by Doctor Berglund (current AMPAC chairman); Donald K. Crandall, MD, Muskegon (Council on Medical Service); Louis R. Zako, MD, Dearborn Heights (Council on Legislation); Frank Walker, MD, Grosse Pointe Farms (Council on Long Range Planning and Development); E. James Potchen, MD, East Lansing (Council on Medical Education); and Peter A. Duhamel, MD, Rochester (Hospital Medical Staff Section governing council). In addition, the names of Robert D. Allaben, MD, Detroit, and Jay K. Harness, MD, Ann Arbor, have been submitted for nomination by the AMA Board of Trustees for positions on the Councils of Constitution and Bylaws and Medical Education, respectively, to be voted on in June, 1987.



Your Michigan delegation is, of course, vitally interested in the many issues that come to the AMA House of Delegates as either board/council reports or state association/specialty society/section resolutions. At the interim meeting in December, the delegates considered 95 reports and 143 resolutions. While problems related to PRO regulations dominated the discussion in lengthy debate, a number of other issues affecting the future of medical practice and medical education were on the agenda. Many of these have been reported and discussed in *Medigram* and county medical society publications and at various meetings around the state. Included were reports and resolutions on physician DRGs, guidelines on AIDS, negotiations by physicians, Medicare reimbursement, adolescent health, and a status report on the Health Policy Agenda for the American People.

New strategic plan

In a major effort to strengthen public and professional confidence in the AMA, the delegates adopted a new strategic plan for the Association. As adopted, the AMA's new key objective reads:

"The key objective of the AMA is to contribute to the professional and personal development of member physicians and to the betterment of the health of the public by developing and distributing information; by advocating health-related rights, responsibilities, and issues; and by representing the profession as a whole where the image, expertise and national scope of the AMA prove useful. This is to be done in a manner that is cost-effective, protects physician autonomy and self-determination, improves the practice of medicine, and builds public confi-

Continued on next page

AMA TEAM/Continued

dence in the competence and reliability of physicians."

The Michigan delegation has introduced a number of resolutions to the AMA House over the past several years. Most of them have been adopted, while several key resolutions have been referred. At the June, 1986 annual meeting, in response to the concerns of Michigan physicians on the liability crisis and the protection of retirement plans, your Michigan delegation requested that the AMA take necessary action to exempt retirement plans from bankruptcy and other creditor collection proceedings, and to pursue such amendments to federal law as necessary to accomplish that objective. This resolution was referred to the AMA Board of Trustees, which currently is studying this problem and will provide a report in June, 1987.

This past December, a Michigan resolution asking for establishment of an AMA Section on Foreign Medical Graduates was referred to the Board of Trustees, with the request that they develop a plan of action intended to increase the active involvement and membership of foreign medical graduates in the AMA, with the formation of a section as an option. This has been referred to the Council on Long Range Planning and Development, and Busharat Ahmad, MD, Marquette, and Robert E. Paxton, MD, Fremont, already have presented the Michigan position on this matter to the Council. We anticipate the response to this Michigan resolution will be both timely and satisfactory.

I hope this brief report has stimulated interest on your part in both membership and participation in activities and support of policies of the American Medical Association. AMA House meetings provide a unique educational opportunity and I would encourage you to attend and participate. Any member of the Association may present testimony at the reference committee hearings and, of course, corridor discussions on the issues provide additional opportunities to get your views across.

If you can't come to the meeting you can still be represented through your delegate. Let him or her know your opinions. You also can prepare a resolution and request that it be submitted to the House.

Many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process. We welcome your questions and suggestions. ☐

Here's the Michigan AMA family

Members of AMA Councils from Michigan

Baker

Crandall

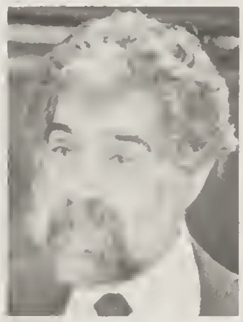
Richard J. McMurray, MD, Flint
Council on Ethical and Judicial Affairs
Louis R. Zako, MD, Dearborn Heights
Council on Legislation

McMurray

Potchen

Frank B. Walker, II, MD, Grosse Pointe Farms
Council on Long Range Planning and Development
John A. Baker, East Lansing
Council on Medical Education

Walker

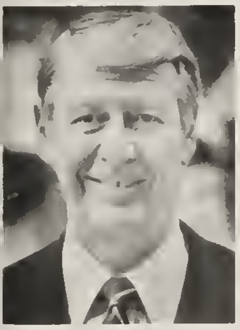

Zako

E. James Potchen, MD, East Lansing
Council on Medical Education
Donald K. Crandall, MD, Muskegon
Council on Medical Service

MSMS Delegates to the AMA

Allaben

Baumann


Gascoigne

Harness

Berglund

Burton

Walker

Crandall

Gagliardi

Robert D. Allaben, MD, Detroit
Billy B. Baumann, MD, Pontiac
Thomas R. Berglund, MD, Portage
Robert D. Burton, MD, Grand Rapids
Donald K. Crandall, MD, Muskegon
Carl A. Gagliardi, MD, Dearborn

Continued on next page

AMA DELEGATES/Continued

Richard H. Gascoigne, MD, Adrian
Jay K. Harness, MD, Ann Arbor
Frank B. Walker, MD, Grosse Pointe Farms
Two vacancies

Alternate Delegates

Busharat Ahmad, MD, Marquette
Robert W. Black, MD, Detroit
R. Jack Chase, MD, Grand Rapids
Gerald H. Mandell, MD, Detroit
Robert E. Paxton, MD, Fremont
Thomas C. Payne, MD, Lansing
Rhoda M. Powsner, MD, Detroit
Richard L. Rapport, MD, Flint
James H. Tisdel, MD, Port Huron
Louis R. Zako, MD, Dearborn Heights
Eric L. Shampaine, student representative, Ann Arbor

AMA Specialty Society Delegates from Michigan

James J. Humes, MD, Detroit
E. James Potchen, MD, East Lansing
Chris J. D. Zarafonetis, MD, Ann Arbor
Michael J. Sullivan, MD, resident representative, Farmington Hills

Alternate Specialty Delegates

Duane L. Block, MD, Dearborn
Kenneth L. Krabbenhoft, MD, Pleasant Ridge
Clarence S. Livingood, MD, Grosse Pointe
Laurie G. McKeown, Medical student section, Ann Arbor

AMA Medical Student Section Delegation

Jack Baker, Michigan State University
Dan Henley, Michigan State University
Curtis F. Mack, University of Michigan
Toni M. Love, University of Michigan
John A. Hopper, Wayne State University
Robert Pritchard, Wayne State University

AMA Resident Physician Section Delegation

Walter Talamonti, MD, Melvindale
Gary Gustafson, MD, Berkley
Eric Groskin, MD, Oak Park
Edward Jankowski, MD, Riverview

AMA Young Physician Section Delegation

Richard A. Stone, MD, Mt. Clemens
Domenic Federico, MD, Grand Rapids

AMA Hospital Medical Staff Section Delegation

J. L. Anderson, MD, Flint
Ned I. Chalat, MD, Detroit
Harry L. Doerr, MD, Farmington Hills
Henry M. Domzalski, MD, Detroit
Kevin Drumm, MD, Warren
Peter A. Duhamel, MD, Rochester
Gerhard C. Endler, MD, Detroit
R. D. Gibson, MD, Newberry
G. Malek Hedayat, MD, Harper Woods
Louis E. Heideman, MD, Birmingham
Michael Iacobellis, MD, Dearborn
Barbara J. Jenkins, MD, Detroit
James E. Kalkley, MD, Grosse Pointe
Sheldon M. Kantor, MD, Southfield
Jose O. Kleer, MD, Garden City
Gary D. Maynard, MD, Kalamazoo
John H. McLaughlin, MD, Birmingham
Mark McQuiggan, MD, Detroit
John L. Pfenninger, MD, Midland
Samir Ragheb, MD, Warren
K. K. Sawhney, MD, Taylor
Natwarlal Shan, MD, Detroit
Narinder K. Sherma, MD, Southfield
James Stanton, MD, Mt. Clemens
James F. Stoddard, MD, Bay City
Thomas E. Stone, MD, Muskegon
Lionel F. Swan, MD, Detroit
Andrew Tastervail, MD, Pontiac
Arthur A. Ulmer, MD, Grosse Pointe
James Whitten, MD, Southfield □

AMA irons in the fire boil down to quality care

By John J. Coury, Jr., MD

It's hard to imagine that I've been serving as your president for so many months. Time has been in high gear and I've crossed off the months as if they were weeks. But as I look back on my schedule, I can account for every day—every speaking appearance—so I know that I haven't slipped into some Rip Van Winkle-like trance. But just like Washington Irving's sleepy hero, we in medicine are confronted by a changing world, from new techniques to new technologies, from new diseases to new delivery systems.

As I've traveled, I've talked with many physicians who are discontent because of the changes we're experiencing. And we all know that in medicine, change is abundant. It's inevitable. Change is constant.

But along with change comes opportunity, opportunity to advance as individuals, and as a profession. To do that we need to master the forces restructuring the medical world. We need to understand the advantages and the liabilities of these new medical procedures and advanced equipment. And just as importantly, we need to understand the benefits and drawbacks to the emerging delivery systems.

Many of the complaints I've heard come from physicians who have been quick to join the latest prepaid health care plan, only to learn that the plan has overpromised and underbid, and they find themselves in financial jeopardy.

Society depends on us to guarantee that whatever changes may come, one thing that will not change is quality.

Doctor Coury

We must all be keenly aware of the risks we could face before we subscribe to any of these plans. And above all, we need to remember that while fees may be negotiable, and while we may have latitude in prescribing treatments and procedures, that quality care cannot be compromised.

Society depends on us to guarantee that whatever changes may come, one thing that will not change is quality. And because of that tremendous burden we bear, the public still has a high degree of respect for physicians. In a recent study, we found that of six professional groups— those who work on Wall Street, politicians, doctors, reporters, lawyers and corporate executives—the public rated doctors as having the highest ethical standards.

A host of problems

But there's one great irony in holding this esteemed position, because in spite of the tremendous strides we've made in improving the quality of life in this country, physicians have been beset by a host of new problems, problems such as the professional liability crisis.

In our survey of physicians this year, we documented what most of you already know. Professional liability is viewed as the main problem facing medicine today. Over one-third of the physicians polled gave us that response, way up from the two percent who gave us that answer in 1983.

This year, 26 state legislatures enacted some measure of tort reform, but it hasn't been enough—we all realize that. Nearly half of the physicians interviewed reported that they were not satisfied with current tort law reforms. And our efforts to get Congress to do something about this crisis have not yet been successful, in spite of the fact that

Continued on next page

The author, AMA President John J. Coury, Jr., MD, Port Huron, gave this address at the interim meeting of the AMA House of Delegates.

QUALITY/Continued

Senator Orrin Hatch introduced a bill based on model legislation that we had developed.

But, we haven't given up. The 100th Congress convened in January, and the AMA is there to push for legislation that will encourage states to pass significant tort reforms where needed, not just token reforms as some states have done.

But we are also looking to the future, beyond tort reform. We have a once-in-a-generation opportunity to design an alternative system for resolving professional liability claims. 1987 may be the pivotal year when such a nonjury liability system is ready to become a marketable demonstration project.

And in another area where change is required, we've discovered that we need to take a good look at the total health care picture in this country, and perhaps focus on areas that have not received the attention they should have. I'm proud that the AMA has taken the lead in these efforts.

A bright spot

One of the real bright spots on the horizon is the work that the AMA and other interested groups are doing on the Health Policy Agenda for the American People. The HPA, as this project is called, is a private and public sector effort to develop a long-term consistent policy approach to the health care issues facing the nation.

All too often, organizations interested in health care have been forced to develop policies or recommend public actions as a result of immediate pressures. What we need is a reasoned, common sense approach to these social, economic, scientific, educational and political situations as they arise. That's the goal of the HPA: to provide the long-term policy development framework required for a consistent approach to the health care challenges we face as a nation.

The HPA was initiated by the AMA Board of Trustees in 1982, but we have always thought of it as a multi-organizational project. Since then, it has expanded to include more than 170 other concerned organizations. The HPA report was released to the public in February. We will consider the report's recommendations at our annual meeting next June, and other organizations will do the same throughout 1987.

Besides the much needed direction the HPA will provide, there has been an important by-product. All of the participants have developed a better understanding of each other during the past months of hard work and planning. I think these improved relations will give the implementation phase of this project a big boost and will help us build strong coalitions around some of the important HPA goals.

And there's another AMA activity that I'm very proud of—our recognition of the need for closer attention to the medical needs of adolescents. We've always regarded our young people as our greatest resource, the key to our nation's future. But many of them will never grow to adulthood, their lives cut short by suicide, drugs, tobacco and alcohol abuse, violent crime and unfortunate, but preventable, accidents. And many of those who become adults will bear the emotional and physical scars of child abuse, teenage pregnancy, drug dependency and eating disorders such as anorexia and bulimia.

When you think of it, there is probably no other professional group better qualified than physicians to sponsor a call for a truly comprehensive approach to understanding—and meeting—the health needs of our young people. Public health advocacy has long been a hallmark of organized medicine. This is just one more step in that long tradition of advocacy.

Peer review

And medicine has another long tradition, a tradition of peer review that protects both the quality of care our patients receive and the efficiency with which that care is delivered. In recent years the spectre of anti-trust restrictions has threatened medical society physician peer review. Earlier this year your American Medical Association asked the

United States Justice Department "whether good faith peer review activities designed to prevent incompetent physicians from obtaining or maintaining staff privileges violate the anti-trust laws."

The Department of Justice has just sent us a very important letter which indicated in part and I quote, "the anti-trust laws protect competition, not competitors." And then the letter advises, and I quote, ". . . it bears repeating that the anti-trust laws do not stand in the way of physicians' participation in hospital peer review conducted to identify and restrain incompetence in the provision of health care. To the contrary, because such peer review enhances both the quality and efficiency of the services delivered in our nation's hospitals to the benefit of consumers, it furthers the anti-trust goals of fostering competition on the health care marketplace."

The advice in this letter is of great significance. It gives us the opportunity to know once again that we can act in the best interests of our patients. I ask that each of us encourages and sets in motion strong peer review activities in our local hospitals. By doing so we will continue to serve our patients well.

I said, when I began, that change brings about opportunity. Sometimes change has been thrust upon us, sometimes we have set the pace of innovation. However change has come, looking back over the centuries, we can clearly see that medicine, as a science, has been progressing, wiping out age-old scourges and attacking new, modern afflictions. And those mounting the attack are sitting right here—members of organized medicine and the thousands and tens of thousands you represent.

Let us be committed to implementing those crucial changes that the Health Policy Agenda will require; to reforming the American Tort system; and to again forcefully conducting strong peer review. These are programs that demand our attention and support. We're here, as always, to demonstrate our fundamental concern that our patients receive quality of care they need and are entitled to. That's our solemn duty. And nothing, my friends, can change that. ☐

Doctor Coury keeps a hectic schedule

Being AMA President means spending one day in Minnesota, the next in Connecticut, the following three in Utah and the weekend in Texas. Then it's off to Michigan, Indiana, Florida, Illinois. . . .

Sound hectic? It is, according to Delores Pavela, AMA director of the Office of Officers Services. She is in charge of coordinating Doctor Coury's calendar. "His schedule is at least as busy, if not busier, than the typical AMA president's," she said. He tries hard to honor his commitments at home and in his surgical practice. "He's wonderful!" she added. "He has been one of the most well-liked AMA board members."

Here are highlights of Doctor Coury's calendar since his inauguration:

July/August: Met with the Assn. of Pakistani Physicians, Washington, DC; MSMS Midsummer Board Meeting; Idaho Medical Assn.; Indiana U. and Purdue; West Virginia State Medical Assn., and Midwest Surgical Assn., Mackinac Island.

September/October: Met with a Minnesota insurer; Connecticut State Medical Society; Utah State Medical Assn.; Texas Medical Assn.; Jackson (Michigan) County Medical Society; Indiana State Medical Assn.; Florida Assn. of General Surgeons; Health Policy Agenda Steering Committee, Chicago; Kentucky Medical Assn.; AMA Auxiliary, Chicago; Flint (Michigan) Rotary Club; AMA Board of Trustees, Chicago, and Western Medical Assn., California.

November/December: Went to the Duluth Clinic; Oakland County (Michigan) Medical Society; North Central Medical Conference, Minnesota; Southern Medical Assn., Atlanta; Michigan Assn. of the Professions; AMA Board of Trustees and Interim Meeting, Las Vegas, and three stops in Detroit.

January/February: Attended AMA State Health Legislation Meeting, Orlando; Rotary in Utah, Arizona and Colorado; AMA Auxiliary, Chicago; Health Policy Agenda Steering Committee, Washington, DC; American Nurses Assn., Chicago; Baton Rouge Rotary; AMA Board of Trustees and Leadership Conference, Chicago; Health Policy Agenda Implementation Committee, Washington, DC, and three California county societies.

This month: Doctor Coury was in Fresno, Houston, Saginaw and. . . China!

Unified membership in Michigan—is this for us?

By Cathy O. Blight, MD

Spirited debate surrounded the unified membership question at the MSMS House of Delegates meeting last May. Unified membership requires that if a physician joins any medical society, he or she must join all three—the county, state and national societies. The delegates adopted the bylaws requirement designating this meeting as "first reading" for this proposed bylaws amendment. The "second reading" will occur in May, 1987, making unified membership effective for 1988.

Some delegates expressed concern that requiring membership at all three levels of organized medicine would cause many physicians to drop out altogether. During the debate, MSMS past president Donald K. Crandall, MD, Muskegon, said, "Last year the AMA subsidized our insurance company's premiums by $300 per member. That means our members got a direct cash benefit greater than the amount of their AMA dues. It's time to pay if we want the benefits of organized medicine."

John J. Coury, MD, Port Huron, AMA President, said, "Let's crawl before we walk, and get the facts before we vote. If the facts prove this is the proper thing to do, let the movement gain momentum and let's have unified membership. If not, then we will know how to vote."

The author, Doctor Blight, Flint pathologist, is chairman, MSMS Committee on Membership Recruitment and Retention.

Today, the AMA strongly favors unification and is urging state and county societies to choose unified membership.

Doctor Blight

Peter McCabe, MD, then-president of Wayne County Medical Society, and Susan Adelman, MD, former WCMS president, both spoke against the unified membership proposal, citing specific numbers of members who would resign or retire from membership.

Not a new issue

This is not a new issue. It has been kicking around since 1950. Before 1950, the AMA did not charge its members dues; all states were in effect unified with AMA, since all members of the state medical societies were considered to be AMA members. By subscribing to the *Journal of the AMA (JAMA)* a state society member became a "Fellow" of the AMA.

In 1950, the AMA instituted dues-paying membership. In response, some state societies, including Illinois and Oklahoma, adopted a policy of unified membership, which required that all their members must become dues-paying AMA members in order to retain their state society membership.

Unified membership grew between 1950 and 1962. In 1962, 13 states were unified with the AMA. These states accounted for 40 percent of AMA membership, and more than 70 percent of American physicians were AMA members.

Then the trend reversed. States chose to de-unify. By the end of 1984, only two states—Illinois and Oklahoma—remained unified. These two states accounted for only nine percent of AMA membership, and only 45 percent of physicians were AMA members.

Today, the AMA strongly favors unification and is urging state and county societies to choose unified membership. The AMA asserts that the drop over the last 20 years in the percent of physicians participating in AMA restricts the society's ability to represent American physicians, because critics can point to the fact that the AMA represents less than half of its self-proclaimed constituency. Also, dues receipts from less than a majority of American physicians restricts

AMA's activities and effectiveness.

To encourage state and county societies to choose unified membership, the AMA offers a battery of incentives: 1) the AMA would not allow direct AMA membership in states that unify, thus pressing its current direct members to join their state and county societies; 2) the AMA would offer a 10 percent discount on AMA dues to members in states that unify; 3) if unified, Michigan could possibly be entitled to one or two additional members in its AMA delegation, providing there is a substantial increase in membership. (The delegations currently consist of one delegate per 1,000 members.)

No one can predict with accuracy how many AMA direct members would join MSMS if unification were required or how many current MSMS members would drop their membership. Reports of the experience of other states that recently have unified are mixed. The AMA reports that halfway through the first year of unification, the Mississippi State Medical Association increased its membership by seven percent, but Kansas lost 3.3 percent. In Virginia, only 150 members resigned specifically because of unification. However the May 26, 1986 issue of *Medical Economics* reports that one-eighth of Virginia's 6,500 members (more than 800 members) either resigned or had not paid dues in protest over the unification requirement, because, they say, they either dislike the AMA's image or they resent not being allowed to vote on mandatory unification.

Reports of the experience of other states that recently have unified are mixed.

MSMS projections

The fact sheet drawn up by MSMS estimates that MSMS would gain $170,000 in the first year of unification, assuming that 50 percent of AMA direct members would join MSMS to retain their AMA membership and 70 percent of MSMS/non-AMA members would join AMA under unification.

Physicians are specialists who join their specialty societies as the best means of keeping abreast of developments in their area of specialization. For them, membership in the AMA may seem redundant and less appealing than membership in their specialty society. Furthermore, Michigan physicians are hurting over liability insurance premiums and worry about the threat of litigation. A requirement that they find the additional funds for AMA dues may cause some to toss in the towel for organized medicine. Others will go along with the requirement in order to maintain their professional credentials.

. . . the proposal will be considered again in 1987 with the opportunity for amendment or disapproval . . .

In addition to adopting the bylaws changes that unified membership would require, the MSMS House of Delegates at its 1986 Annual Meeting instructed the Board of Directors to inform the membership that the proposal will be considered again in 1987 with the opportunity for amendment or disapproval at that time. ☐

Editor's note: Following are the final results of the MSMS Unified Membership Survey sent to 8,407 active members:

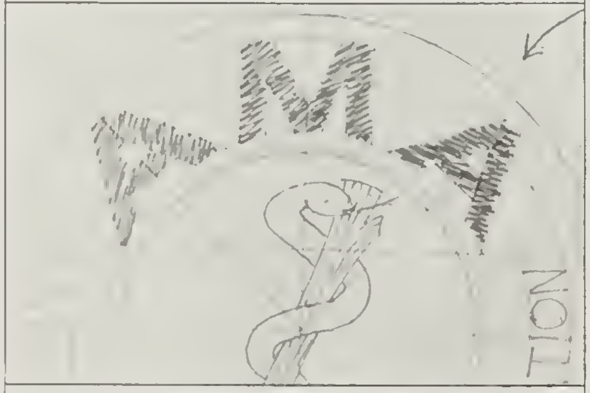
	Frequency	Percent
Favor	1741	36.9
Against	2876	61.0
Neutral or Undecided	106	2.1
TOTAL	4723	100.0%

Building a better AMA: strategies for 1987 and beyond

Here is a summary of new strategic directions for the AMA. This abridged introduction to the 1987 AMA Plan and Budget outlines major new initiatives toward building an attractive, accessible and able AMA.

Over the years, the American Medical Association has earned public trust and professional support by serving as the stalwart guardian of high quality medical care for all Americans. By doing so, the Association has earned a reputation of competence and credibility, without which it could not speak or act as effectively in representing the shared interests of the profession and the public.

Clearly, the years ahead will be marked by growing numbers of physicians, increased diversity and fragmentation of professional interests, continuing government regulation and intensifying pressures on the Association's narrow margin of revenues over expenses. Despite the strong interest in quality shared by the profession and the public, controversy will continue between physicians and others as solutions are sought to resolve complex problems.



The need for unified national representation that the AMA, and only the AMA, can provide will persist. To function most effectively, the AMA will need the stature and scope made possible by the active support of a significant majority of physicians as well as high levels of public trust and confidence. To obtain this support, the AMA's competence, objectivity and commitment to excellence must be demonstrated in a highly visible manner to the profession and the public.

Toward this end, a set of new strategic directions for the Association are summarized in this report and outlined in detail in Board of Trustees Report PP (I-86).

AMA purposes

More than a century ago, the objects of the Association were written into the AMA's Constitution as follows: "to promote the science and art of medicine and the betterment of public health." Over the years, these objects have provided the broad framework within which the Association has pursued its four fundamental purposes:

1) Representation of the medical profession; 2) Provision of information related to medicine; 3) Establishment, implementation and maintenance of standards of conduct and performance; and 4) Participation in the establishment, implementation and maintenance of standards of medical education.

To ensure its future strength and effectiveness, the AMA—like all other successful enterprises—must continually strive to focus its resources on those areas which have the greatest potential for the maximum benefit to the organization and its members. This can be accomplished by developing a new Association key objective in order to sharpen and clarify the focus and direction of the Association's activities within the context of the more broadly-defined Constitutional objects and fundamental purposes.

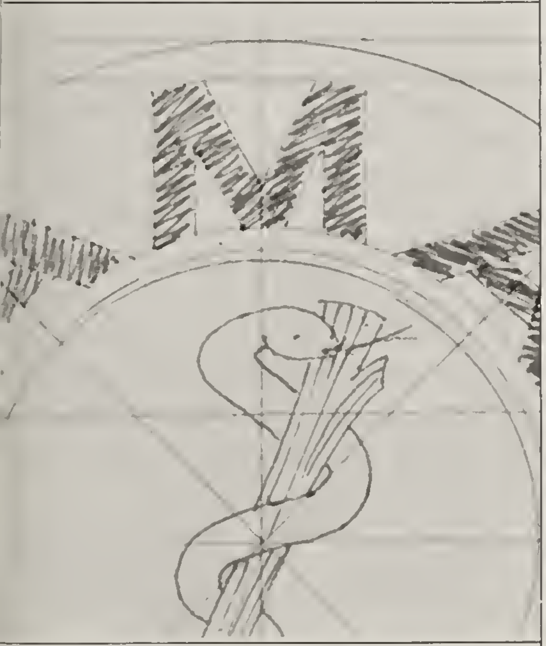
In formulating a new Association key objective, the Board of Trustees affirms that the Association exists to serve both the needs of its members and the health concerns of the American public. Further, the Association's efforts have been, and will continue to be, directed at achieving the following results consistent with the long-standing policies of the House of Delegates:

1) Physicians will maintain a primary commitment to patients under their care; 2) The public will identify physicians who belong the the AMA as those who adhere to the highest standards in medicine; 3) Physicians will continue to

merit an appropriate balance between professional satisfaction, prestige and financial reward so that the profession continues to attract highly motivated, qualified students; 4) The AMA is identified by the public as an organization providing leadership in health care issues which are of benefit to them; and 5) AMA membership is identified by physicians as an essential ingredient in achieving these results for themselves and their profession.

Key objective

At the 1986 Interim Meeting, the House of Delegates adopted the following new Association key objective to achieve the previously-stated results and to guide and sharpen the focus of Association activities in the years ahead:



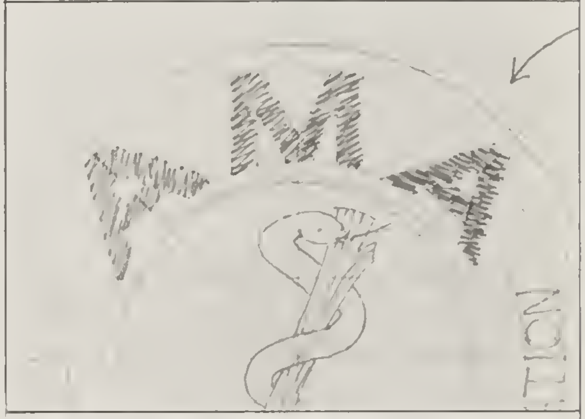
The key objective of the American Medical Association is to contribute to the professional and personal development of member physicians and to the betterment of the health of the public by developing and distributing information; by advocating health-related rights, responsibilities and issues; and by representing the profession as a whole where the image, expertise and national scope of the AMA prove useful. This is to be done in a manner that is cost-effective, protects physician autonomy and self-determination, improves the practice of medicine and builds public confidence in the competence and reliability of physicians.

Key strategies

While there may be any number of approaches to fulfill a particular objective, the strategies selected for implementation generally represent those which offer advantages to the organization that others do not. The Board of Trustees believes that these key strategies provide the most effective approach to position the organization to meet the challenges it will face in the years ahead.

Strategy 1: Strengthen the Association's visibility among the profession and the public while enhancing its reputation for competence, objectivity and commitment to excellence. This is to be accomplished in the following manner:

- By strengthening the organization's position as a concerned, knowledgeable, authoritative and leading advocate of the rights and responsibilities of the public and the profession regarding health care concerns;
- By providing an expanded array of informational products and services to serve identifiable needs of the profession and the public; and



- By enhancing the effectiveness of AMA's public communications program to aid in increasing the public's and the medical profession's understanding of the key changes that are occurring in health care delivery and the impact of such changes on health care quality and access.

Strategy 2: Shift the development of Association products and services from a product-driven to a market-driven approach based on an accurate determination of physician and public needs as well as a realistic appraisal of the likelihood for a positive return on the Association's investment. This is to be accomplished in the following manner:

Continued on next page

STRATEGIES/Continued

- By ensuring that the Association's marketing function receives a high level of visibility and support throughout the AMA by the establishment of a new position entitled Vice President, Marketing;
- By developing and implementing a comprehensive marketing plan; and
- By ensuring that the Association receives full recognition for all of its activities, products and services through the establishment and implementation of a coordinated program of corporate identification.

Strategy 3: Visibly personify the best in medicine by promoting excellence in health care and in all that the Association does and represents.

Strategy 4: Utilize the Association's key objective as a driving force to redirect and sharpen the focus of activities throughout the organization and to enhance the AMA's management structure and process to facilitate the most effective and efficient implementation of such activities.

Key needs and new initiatives

Highlighted here are ten areas that have been identified as Association key needs for 1987. Included with each area are a number of Association activities that are planned to respond to the various needs. Such initiatives encompass only a small portion of the Association's total activities planned for the year ahead:

Enhancement of the AMA's reputation for excellence by assuring quality standards in medical education and health care as well as in all that the Association does and represents.

If the Association is to be perceived by the profession and the public as the standard-bearer for excellence in medicine, it must build and maintain a national reputation for integrity, objectivity and excellence. There are a number of ways in which this can, and will, be accomplished in the years ahead:

- *Image of excellence*—AMA's new strategic directions recognize that the Association cannot, nor does it wish to represent *all* physicians; rather, it will be the standard-bearer for the best in medicine. This will, in turn, result in a growing public perception that physicians who belong to the AMA are among those who adhere to the highest standards in medicine. Further, the AMA's concern with the health of the public will be confined to advocating only the highest standards in health care.
- *Quality assurance*—A strong and relentless advocacy will be maintained in the legislative and regulatory arenas to ensure that quality of care is the foremost concern as solutions continue to be sought to the problem of high health care costs. This will be done in a manner that exemplifies knowledge, authority and fairness so that the delicate balance between the interests of physicians and others will be maintained.
- *Educational standards*—AMA's long-standing commitment to the development of educational policy and the preservation of high standards in medical education will continue to be strengthened.
- *Medical ethics project*—In 1987, the Council on Ethical and Judicial Affairs will produce and distribute, in conjunction with a major ethics center, a series of videotape primers on ethics and medicine. The videotapes will provide a useful introduction for the teaching of ethics in medical schools and in residency programs.

Continued provision of strong and effective leadership and advocacy on health-related matters of concern to the profession and the public.

AMA's policy and influence bases will continue to be utilized in such a way to cause legislative and judicial actions that are consistent with the Association's policy positions; are responsive to

Continued on page 156

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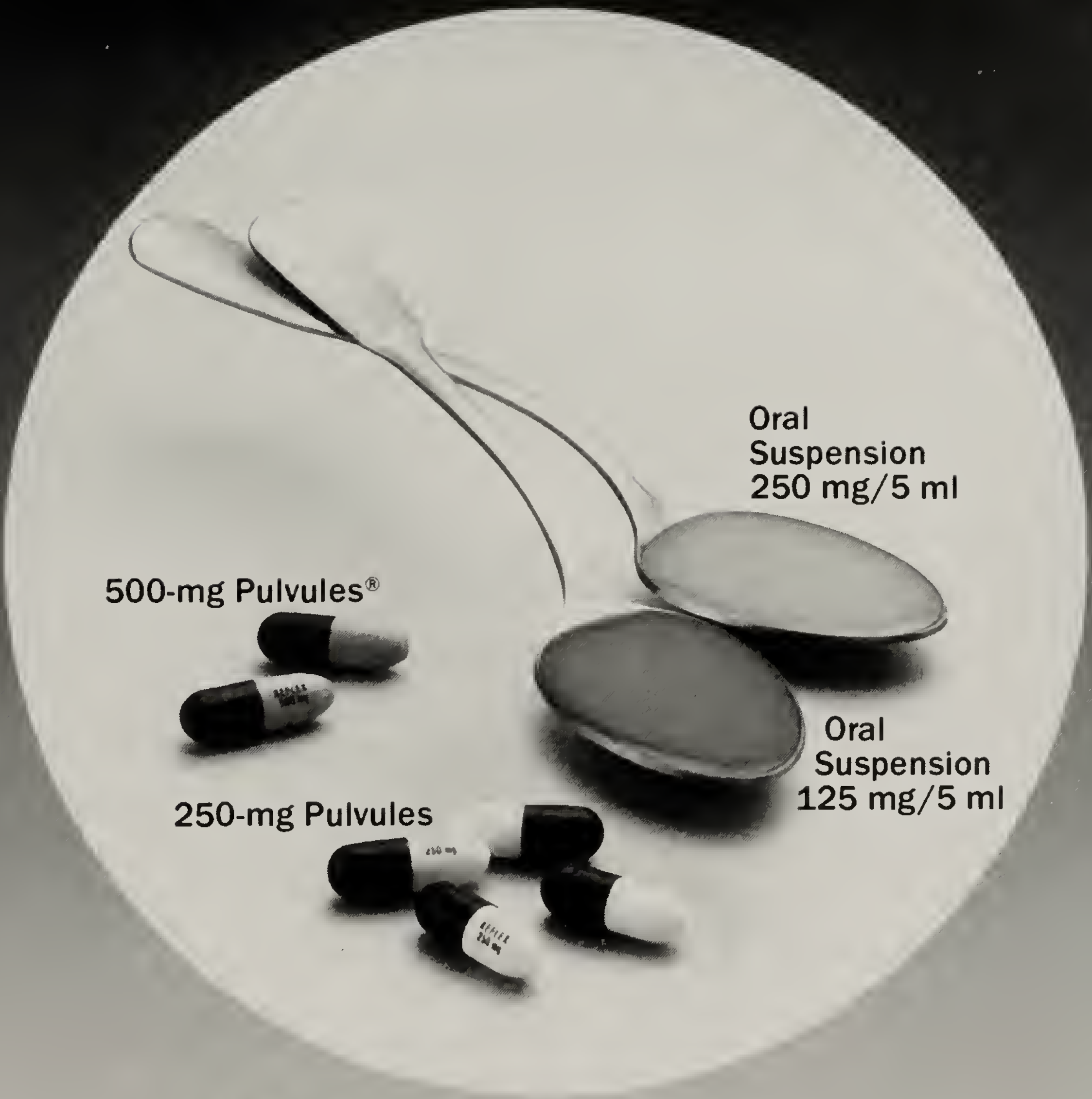
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SYNCHRONIZED SULFONYLUREA THERAPY

Please see brief summary of Glucotrol® (glipizide) prescribing information on next page.

ROERIG Pfizer
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Reference:
1. Sachs R, Frank M, Fishman SK Overview of clinical experience with glipizide in *Glipizide A Worldwide Review* Princeton, NJ, Excerpta Medica, 1984 pp 163-172

GLUCOTROL® (glipizide) Tablets
Brief Summary of Prescribing Information

INDICATIONS AND USAGE: GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) after an adequate trial of dietary therapy has proved unsatisfactory

CONTRAINDICATIONS: GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin

SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY: The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (*Diabetes*, 19, supp. 2:747-830, 1970).

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2-1/2 times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of GLUCOTROL and of alternative modes of therapy.

Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

PRECAUTIONS: Renal and Hepatic Disease: The metabolism and excretion of GLUCOTROL may be slowed in patients with impaired renal and/or hepatic function Hypoglycemia may be prolonged in such patients should it occur

Hypoglycemia: All sulfonylureas are capable of producing severe hypoglycemia Proper patient selection, dosage, and instructions are important to avoid hypoglycemia Renal or hepatic insufficiency may increase the risk of hypoglycemic reactions Elderly, debilitated or malnourished patients and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs Hypoglycemia may be difficult to recognize in the elderly or people taking beta-adrenergic blocking drugs Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used

Loss of Control of Blood Glucose: A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery It may then be necessary to discontinue GLUCOTROL and administer insulin

Laboratory Tests: Blood and urine glucose should be monitored periodically Measurement of glycosylated hemoglobin may be useful

Information for Patients: Patients should be informed of the potential risks and advantages of GLUCOTROL, of alternative modes of therapy, as well as the importance of adhering to dietary instructions, of a regular exercise program, and of regular testing of urine and or blood glucose The risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members Primary and secondary failure should also be explained

Drug Interactions: The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including nonsteroidal anti-inflammatory agents and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, coumarins, monoamine oxidase inhibitors, and beta adrenergic blocking agents *In vitro* studies indicate that GLUCOTROL binds differently than tolbutamide and does not interact with salicylate or dicumarol However, caution must be exercised in extrapolating these findings to a clinical situation Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens oral contraceptives, phenytoin, nicotinic acid sympathomimetics, calcum channel blocking drugs, and isoniazid A potential interaction between oral miconazole and oral hypoglycemic agents leading to severe hypoglycemia has been reported Whether this interaction also occurs with the intravenous, topical, or vaginal preparations of miconazole is not known

Carcinogenesis, Mutagenesis, Impairment of Fertility: A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity Bacterial and *in vivo* mutagenicity tests were uniformly negative Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on fertility

Pregnancy: Pregnancy Category C GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg) This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL In studies in rats and rabbits no teratogenic effects were found There are no adequate and well controlled studies in pregnant women. GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Because recent information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible

Nonteratogenic Effects: Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery This has been reported more frequently with the use of agents with prolonged half-lives GLUCOTROL should be discontinued at least one month before the expected delivery date

Nursing Mothers: Since some sulfonylurea drugs are known to be excreted in human milk insulin therapy should be considered if nursing is to be continued

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS: In controlled studies the frequency of serious adverse reactions reported was very low Of 702 patients, 11 8% reported adverse reactions and in only 1 5% was GLUCOTROL discontinued

Hypoglycemia: See PRECAUTIONS and OVERDOSAGE sections

Gastrointestinal: Gastrointestinal disturbances, the most common, were reported with the following approximate incidence nausea and diarrhea, one in 70 constipation and gastralgia, one in 100 They appear to be dose-related and may disappear on division or reduction of dosage Chloestatic jaundice may occur rarely with sulfonylureas GLUCOTROL should be discontinued if this occurs

Dermatologic: Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria pruritus and eczema have been reported in about one in 70 patients These may be transient and may disappear despite continued use of GLUCOTROL, if skin reactions persist, the drug should be discontinued Porphyria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia aplastic anemia, and pancytopenia have been reported with sulfonylureas

Metabolic: Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions

Endocrine Reactions: Cases of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) secretion have been reported with this and other sulfonylureas

Miscellaneous: Dizziness drowsiness, and headache have been reported in about one in fifty patients treated with GLUCOTROL They are usually transient and seldom require discontinuance of therapy

OVERDOSAGE: Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia If hypoglycemic coma is diagnosed or suspected the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg dL Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease Because of the extensive protein binding of GLUCOTROL (glipizide), dialysis is unlikely to be of benefit

DOSAGE AND ADMINISTRATION: There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL, in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia

Initial Dose: The recommended starting dose is 5 mg before breakfast Geriatric patients or those with liver disease may be started on 2 5 mg Dosage adjustments should ordinarily be in increments of 2 5-5 mg as determined by blood glucose response At least several days should elapse between titration steps

Maximum Dose: The maximum recommended total daily dose is 40 mg

Maintenance: Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing Total daily doses above 15 mg should ordinarily be divided

HOW SUPPLIED: GLUCOTROL is available as white, dye-free, scored diamond-shaped tablets imprinted as follows 5 mg tablet—Pfizer 411 (NDC 5 mg 0049-4110-66) Bottles of 100, 10 mg tablet—Pfizer 412 (NDC 10 mg 0049-4120-65) Bottles of 100

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Is there a doctor in the House? No, he's in the Senate

By Sheri W. Greenhoe, Managing Editor

After the election they were calling him Doctor Mayor Senator Schwarz. But, whether you call him Doctor or Senator or Mayor or John, he'll tell you that he "just wants to be known as the Senator who has done a terrific job in Lansing who also *happens* to be a physician."

Senator John J. H. Schwarz, MD (R-Battle Creek) is a practicing physician on Mondays, Fridays and Saturdays and a freshman lawmaker the rest of the time. He admits that's a hectic schedule, and credits his able nurse clinician with keeping his otolaryngology practice running smoothly in his absence.

Keeping the Senate side of his life running smoothly is his other specialty. After eight years of experience in city government—two of those as mayor of Battle Creek—the doctor Senator is an experienced and motivated public servant.

"It gives a new dimension to the legislature to have a real live practicing physician actually a member of the Senate," he says.

While his most recent campaign was his second attempt to obtain a Senate seat, he says comparing the two runs is like comparing apples and oranges.

"Ten years ago there was a bunch of younger Republicans in the third Congressional District that felt the incumbent wasn't doing anything to insure his incumbency. We could see disaster down the road," he says. A figurative flip of the coin determined the group's candidate. "I guess it turned out to be me," he grins.

Sen. John Schwarz, MD

"It gives a new dimension to the legislature to have a real live practicing physician actually a member of the Senate."

"We didn't hold out a whole lot of hope of winning the election, but we hoped we would send the incumbent congressman a message that he had better start tending to his constituency back home," he says. "That campaign was an exercise in indicating our concern, and I have no regrets about that at all. It was an interesting experience."

His most recent campaign, obviously, was the real thing. He had years of solid Battle Creek experience under his belt and state and county Republican organizations behind him. His hometown physician colleagues volunteered time and money to his race, and Michigan Doctors Political Action Committee (MDPAC) supported him to the legal limit.

"MDPAC 'maxed out' in both the primary and the general elections," he says. "I'm very grateful for that."

"Grateful" is the word he uses, too, to describe his feelings toward being named chairman of the Senate Education and Mental Health Committee.

"I'm grateful for Majority Leader Engler's faith in my ability to do the job on the committee, and I'm grateful for the appointment to the Commerce Committee. The appointment to the Health Policy Committee was a natural," he says.

"I had thought maybe I would ask not to serve on any health-related committees, but my own logic in thinking that way was flawed," he reflects. "It's quite obvious to me after going to a number of caucuses that I can be a contributor in the health field. I shouldn't leave that to the organized health interest groups or to the health interest groups within state government itself. It's important to have expertise within the caucus," he says.

The Health Policy Committee will be "absolutely overrun with people who have things to say about AIDS," he predicts. "My

Continued on page 136

SCHWARZ/Continued

own thought about AIDS right now is to be focused on AIDS the disease." He pointed to Health and Human Services Director Otis Bowen's recent report that the implications of AIDS may indicate that it is the worst epidemiological problem humanity has faced since the beginning of record-keeping.

"I would like the committee, the legislature, the medical special interest groups to focus on finding a treatment, a possible vaccine," Schwarz stresses. "I am less interested, frankly, in dealing with AIDS in terms of the civil libertarian rhetoric that accompanies it. The time for prolonged and learned discussion about the ramifications of certain civil liberties arguments vis-a-vis the possibility of this epidemic being destructive in society is passed."

Building an agenda

His Education and Mental Health Committee is in the process of building its agenda for the session, Committee Chairman Schwarz says.

"We know what six or seven big items are out there, but we want to know what else should be on our agenda." He anticipates that public hearings will boil down to one major theme: "The answer is always, 'provide quality education to the young people of this state.'

"If we can get one or two bits of meaningful legislation through that tighten up the educational system that provoke students, faculty and administrators into recognizing the need for as high a quality education as we can provide, then we will have done our job," he says. "I believe the biggest thing we should have to sell in this state to prospective investors with families is the public education system."

". . . if doctors don't get involved, we're going to get walked over. . ."

Selling this state to business is a major task of the Commerce and Technology Committee, on which Senator Schwarz also sits. He recruited industry to Battle Creek during his tenure there, so he brings expertise and understanding to the committee.

"I think it will be the most active committee assignment I have," he says. "The first hot issue is officers' and directors' liability. I share the feelings of those corporations headquartered in this state that are incorporated under Michigan law. We feel that their officers' and directors' assets are not adequately protected, and I don't feel that we can afford to have the K Marts and the Federal Moguls and others to disincorporate here and incorporate elsewhere."

While Senator Schwarz identifies with those entities, he identifies most strongly with his fellow physicians. "I think it's important to realize that this physician member of the legislature really does, by and large, support the goals of MSMS and the vast majority of physicians."

Thick skin

"Physicians, by nature, are very private people," he observes. "Most of them don't want to get up in front of strangers and espouse their feelings on various and sundry issues." But to hold public office, he says, "You have to do that. And I can assure anybody who thinks they might be interested, it doesn't take long to develop a thick skin."

Senator Schwarz is encouraged by what he saw at a recent Calhoun County Medical Society, of which he is a past president. "They seem to be more politically attuned than they were eight years ago," he says. (Battle Creek City Commission meetings prevented him from attending county medical society meetings.)

That heightened political awareness is good, he says. "I'm here to tell you, folks, that if doctors don't get involved we are going to get walked over from so many different directions, and blindsided by so many different special interest groups, we're not going to know what hit us."

To fend off such attacks, the

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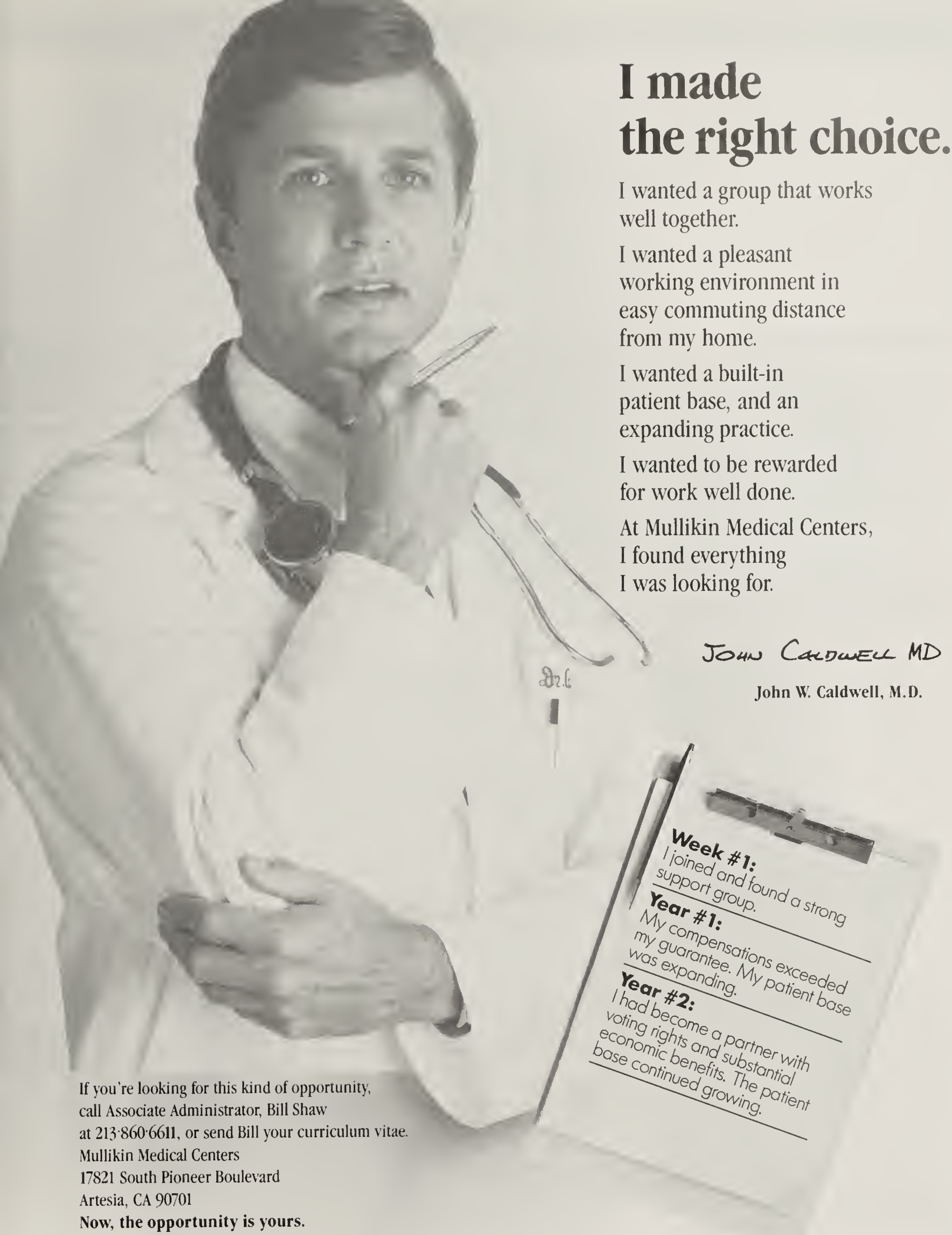

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SCHWARZ/Continued

doctor Senator advises physicians to get to know their lawmakers on a first-name basis. "That way your calls will be answered, your letters will be read and you will be looked upon as a legitimate spokesman for your profession.

"In other words," he says, "get organized, because everyone else out there is organized. I don't think any coalition of special interest groups can stand up to a *really* organized physician lobby.

"When I say *really* organized, I mean a physician lobby that will make the public aware of what's going to happen to medical care, to their free choice of a physician, to health care costs and to the availability of hospital days. The public has embraced and caressed a high level of health care in this country, and they will not tolerate seeing that level go down," he says.

Natural enemies

Physicians have "natural enemies" in the war to protect quality care, he says.

"You have certain groups who look at the medical community as a repository of money and of potential legal action to enhance their own careers. You have to fight these people tooth and nail," he says.

"The only way to do that is to be just as militant and just as focused on your goals as they are on theirs. I don't think we're there yet. It's not the nature of the physician beast to be that focused and single-minded, but," he warns, "it's going to have to come."☐

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"Once you're released, things happen fast!"

Meet the winners in Michigan's legislative elections

Twenty-one individuals were elected to the Michigan legislature last fall. So that our membership might become more familiar with these new public servants, MSMS contacted each of them and asked for biographical information and a response to this question: *What is the legislature's role in promoting the availability of quality health care services in Michigan while at the same time emphasizing the need to contain health care costs?* Twenty lawmakers responded to our request.

House

Rep. William S. Browne
(D-26) Utica
Background: President, Browne & Associates, Management Relations Consultants; Executive Director, Utica Education Association; Teacher, Warren Consolidated Schools; Wayne State University—BA 1962, MA 1967; served in US Navy, 1952-1956.
On health care: No statement.

Rep. Ken N. DeBeaussaert
(D-75) New Baltimore
Background: Entering his third term in the Michigan House of Representatives. His previous legislative service was from 1979-80 and from 1983-84. During his 83-84 term, chaired the Marine Affairs and Port Development Committee which developed legislation to protect the Great Lakes and implement a water management plan; sponsored the first auto "lemon" bill in Michigan. In 1984 Governor Blanchard appointed DeBeaussaert as his representative to the Great Lakes Commission. DeBeaussaert served as Vice-Chair of the Commission for two terms.

On health care: "The Legislature must work in cooperative efforts to develop a balance between health care cost containment and assuring quality medical care. The Legislature must continue working with all interested parties in the public and private sectors to develop new public policies which will meet our objectives."

Rep. Agnes Dobronski
(D-31) Dearborn
Background: Detroit College of Business—Bachelor's degree in accounting; Eastern Michigan University—Master's degree in educational administration. Employed by Dearborn Public Schools for 37½ years. Executive Michigan Retirement Coordinating Council; Member, Dearborn Board of Education — held positions of president, vice president and secretary.

On health care: No statement.

Rep. James A. Docherty
(D-76) Port Huron

Continued on page 141

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REP. DOCHERTY/Continued

Background: Served on Planning Commission and was elected to serve as Trustee of Kimball Township; served on the St. Clair County Board of Commissioners as vice chairman and as chairman; served as chairman of the St. Clair County Board of Auditors; served as State Representative, 76th District, Democratic Majority Whip, Member of Speaker's Ad-Hoc Committee on K-12 education, chairman of Transportation Subcommittee on House Bill 5245.

On health care: No statement.

Rep. Joanne Emmons
(R-99) Big Rapids
Background: Republican Precinct Delegate; Mecosta County Republican vice-chair; Big Rapids Township treasurer; Mecosta County Republican chair; alternate delegate Republican National Convention; 10th District Republican Executive Committee; Michigan Township Association Board of Directors; 10th District Republican vice-chair; Michigan Municipal Treasurers Association Board; West Michigan Health Systems Sub-area Council; West Michigan Health Systems Mental Health Planning Committee; Area Agency on Aging Advisory Board; West Michigan Health Systems Area-wide Review Committee.

On health care: No statement.

Rep. Deborah D. Farhat
(D-97) Muskegon
Background: Community Relations Specialist at Community Mental Health Services of Muskegon County (CMH); appointed by Governor James Blanchard to serve on the three member Michigan Crime Victims Compensation Board; 1986 co-chairperson of the Muskegon Shoreline Spectacular and member of the Muskegon Shoreline Spectacular Planning Committee; member of the City of Muskegon's Economic Development Commission; member of Mental Health Players of Muskegon; CMH representative on the United Way of Muskegon County's Communications Committee; liaison to the Mental Health Advisory Council of the Department of Mental Health; Crime Victims Act Task Force of Muskegon, and previously on the Education Committee for the Muskegon County Council on Child Abuse and Neglect.

On health care: No statement.

Rep. Frank Fitzgerald
(R-56) Grand Ledge
Background: Earned a law degree from Thomas M. Cooley Law School in Lansing after being graduated from the College of William and Mary, Williamsburg, Virginia, with a Bachelor's degree in history. Practiced law in Grand Ledge and then became an Eaton County assistant prosecutor. Formerly served as president of the Capital Library Cooperative; twice elected to the board of trustees of the Grand Ledge Public Library. Fitz-

Continued on page 142

REP. FITZGERALD/Continued

gerald's great-grandfather, John, represented Eaton County in the House of Representatives in 1895-1896. His grandfather, Frank D. Fitzgerald, was twice elected governor of Michigan in the 1930's after being twice elected John W. Fitzgerald, was a two-term state senator before going on the first Michigan Court of Appeals, later serving nine years on the Michigan Supreme Court.

On health care: No statement.

Rep. Sharon L. Gire
(D-72) Mount Clemens

Background: Macomb County Commissioner; Mount Clemens City Commissioner; Mount Clemens Mayor Pro-tem; Northeast Interfaith Center, director; Big Brothers/Big Sisters, Macomb area supervisor; National Board, YWCA, Central Region Teen program consultant. Earned a bachelor's degree in Education from Ohio State University, graduate work in Counseling Psychology, Ohio State University, and MSW degree from Wayne State University.

On health care: No statement.

Rep. Kay M. Hart
(D-83) Swartz Creek

Background: Swartz Creek Elevator accountant/part owner (family owned); former member Swartz Creek City Council; former Mayor of Swartz Creek; President/Treasurer Genesee County Small Cities; Water and Waste Advisory Board; Member Michigan Municipal League; Member Metropolitan Alliance; Genesee County Agricultural Society (Fair Board); 4-H Leader, 15 years; Youth in Government advisor.

On health care: "Michigan's Medicaid program consumes $1.5 billion, half of which is state funding, constituting nearly 16 percent of the state General Fund budget, up from seven percent 10 years ago. Because of these increases 'cost-containment strategies' must be addressed, utilizing the best and rejecting those programs that are burdensome and merely add to the ever increasing costs. Some of those strategies that must be reviewed are: 1) Increasing competition by promoting alternative health care delivery systems; 2) The state certificate-of-need process is a major state regulatory program aimed at controlling health care costs associated with capitol expenditures. Along with these cost-containment procedures, two health care issues which need to be addressed are: A) The development of intervention and prevention programs so that less emphasis is placed on acute care; B) Implementation of programs to assure access to health care for the uninsured."

Rep. Nate Jonker
(D-79) Clio

Background: PhD degree in adult and community education from Michigan State University; former teacher in the Clio and Beecher School districts; served as

Continued on page 144

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James Wright, MD

James Wright

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REP. JONKER/Continued

the educational advisor and aide to Genesee County's Senator Gary Corbin; alternate member of the Michigan Job Training Coordinating Council; sits on the subcommittees on Economic Development and Dislocated Workers; former president of the Clio Area Community Council; editorial writer for the local newspaper, Clio "Citizen of the Year" in 1985.

On health care: "In the next years of public life I'm determined to try to make things work better in order to meet the real human needs in Michigan."

Rep. William Martin
(R-49) Battle Creek
Background: Nine year veteran of the Michigan State Police; veteran of the US Army and Lieutenant in the Michigan National Guard; Associates degree in Law Enforcement from Lansing Community College, attended Eastern Michigan University. Member of the Battle Creek Chamber of Commerce, Lakeview-Harper Creek Exchange Club and a charter member of the Lakeview Optimist Club. Member of the Lakeview Business Association.

On health care: "I believe the role of the legislature is to cultivate an environment of service availability while constraining health care costs. The legislature can best promote these goals by their legislative oversight function in the appropriations process by measured response to the tort reform challenge in Michigan."

Rep. Susan Grimes Munsell
(R-51) Fowlerville
Background: Self-employed as a Certified Public Accountant in Livingston County; graduated with a BA from Michigan State University and received her MBA from the University of Michigan; Iosco Township treasurer; Michigan Tax Information Council, Board Member; Private Industry Council, Board Member; League of Women Voters of Michigan, treasurer, taxation director; League of Women Voters of Livingston County, president, treasurer, editor of "Know Your Livingston County;" Livingston County Republican Party, deputy treasurer; Howell Public Schools Advisory Committee; Livingston Council for the prevention of Child Abuse, consultant, member.

On health care: "One of the most effective ways that the Michigan Legislature can promote the availability of quality health care services in Michigan is to promote the efficient and fair operation of the certificate of need process as conducted by the Department of Public Health and the Health Services agencies. Furthermore, one of the most immediate steps the Michigan legislature can take to contain health care costs is to complete serious and comprehensive tort reform with the expectation that malpractice insurance rates will respond accordingly."

Rep. Roland G. Niederstadt
(D-100) Saginaw

Continued on page 146

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REP. NIEDERSTADT/Continued

Background: Swan Creek Township treasurer; Saginaw County Register of Deeds; Michigan Association of Register of Deeds first vice president; Michigan State Association of Register of Deeds Legislative Committee, chairman; Swan Creek Township Park Committee, chairman; James/Swan Creek/St. Charles Water Board, secretary; Planning Commission, former member; US Army and National Guard.

On health care: "The Legislature should provide any and all incentives and opportunities for both the continuation and expansion of medical facilities. The Legislature must continually monitor fair and reasonable charges and costs for Michigan residents which insure quality care and service."

Rep. Kenneth R. Sikkema
(R-94) Grandville
Background: Market manager, Herman Miller, Inc., Zeeland; former executive director, West Michigan Environmental Action Council, Inc., Grand Rapids; former administrative assistant, State Senator John Otterbacher; former legislative assistant, Michigan House of Representatives. Harvard University, bachelor's degree in history, cum laude; University of Michigan, Graduate School of Business Administration, MBA, with distinction.

On health care: "The Legislature has many roles regarding health care. Specifically, however, the Michigan Legislature needs to keep in mind the following: Efforts to accomplish substantive tort reform must continue; the health care delivery system must be properly organized to avoid the costs associated with over-utilization and duplication; all individuals must have access to quality health care."

Rep. Richard A. Sofio
(D-110) Bessemer
Background: None provided.

On health care: No statement.

Rep. Ilona Varga
(D-3) Detroit
Background: Born in Hungary; employed by the Detroit Board of Education as an aide and later as school service assistant at Beard School. Became city-wide school service assistant to the Parents and Computers Teaching Students (PACTS) workshop; served as administrative assistant to former Speaker Pro-tem Matthew McNeely and administrative aide to the House Committee on Insurance; founder and president, Friends of Beard International; member, Southwest Detroit Improvement Association and Southwest Detroit Crime Prevention Coalition.

On health care:"The Michigan Constitution specifically states that 'The public health and general welfare of the people of the state are hereby declared to be matters of public concern. The legislature shall pass suitable laws for the protection and promotion of the public health.' Recently the Michigan legislature's response has been to increase competition among various health care delivery systems as a means of providing quality health care services at a reasonable cost as well as to support programs which attempt to regulate the duplication of available services. The legislature, along with the federal government, health care payors, medical providers and consumers, should continue to explore further methods of balancing both the quality and cost of care while monitoring the effects of cost-containment measures recently enacted. Two health care issues which need to be addressed are the development of intervention and prevention programs so that less emphasis is placed on acute care and implementation of programs to assure access to health care for the uninsured. In summary, the legislature's role is both to provide a forum for the public and private sectors to work collaboratively and to pass policy as needed to assure quality health care at a reasonable cost."

Rep. Wilfred D. Webb
(D-66) Hazel Park

Background: 36 years of employment with Hazel Park Schools as teacher, counselor, junior high principal, assistant superintendent and superintendent; first elected to the State House of Representatives in June, 1982; re-elected to the State House of Representatives in November 1982 and 1986; Hazel Park Jaycees "Citizen of the Year"; founded Hazel Park Youth Protection Committee in 1952; former member Hazel Park City Council. Graduated from Alma College in 1941, and received Master's and Doctorate degrees from Wayne State University. Wilfred D. Webb Junior High School is named after him.

On health care: No statement.

Senate

Sen. John D. Cherry, Jr.
(D-29) Clio

Background: State Representative 1983-86 Michigan House of Representatives (previous House committee assignments: chairman, Subcommittee on the Environment; vice-chairman House Oversight; member, Conservation and Environment, Labor, Urban Affairs and State Affairs.) AFLCIO Michigan political director; member, Clio area United Way board; former board member, Michigan Tax Information Council; former member, Flint Civil Service Commission; former president, Montrose Summer Recreation; former member, Genesee Community Action Agency Board of Trustees; former president, AFSCME Local 496-B.

On health care: No statement.

Sen. Frederick P. Dillingham
(R-30) Fowlerville

Background: Presently chairman, Senate Human Resources and Senior Citizens; vice chairman, Agriculture and Forestry. As a former state representative in the Michigan House of Representatives, served as vice chairman,

Continued on page 148

SEN. DILLINGHAM/Continued

Mental Health; member, Appropriations; vice-chairman, Labor; Republican Caucus Project 86-format for Republican majority in the House, and on other House committees.

On health care: No statement.

Sen. Christopher D. Dingell
(D-7) Trenton
Background: University of Michigan, bachelor's degree, 1978; Doctorate of Law degree, Detroit College of Law, 1986. Worked for numerous Democratic candidates and has regularly attended local, district and state Democratic party meetings. Member, Economic Club of Detroit; Engineering Society of Detroit; Association of Iron and Steel Engineers; Jaycees; Knights of Columbus; Trenton Sportman's Club; Michigan United Conservation Clubs; Michigan Democratic Party Century Club.

On health care: No statement.

Sen. George Zaven Hart
(D-10) Dearborn
Background: Wayne State University, bachelor's degree, 1951; Dearborn City Councilman 14 years; Wayne County Commissioner for seven years; State Senator elected to 10th District in 1978 and served until 1982.

On health care: No statement. ☐

Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Aurel P. Lipulescu, MD
Action, Date Taken: Suspended six months and one day; fined $1,000.00—Effective January 16, 1987
Reason: Conviction of mail fraud (Blue Cross/Blue Shield); obtaining or attempting to obtain third-party reimbursement by fraud or deceit; lack of good moral character.

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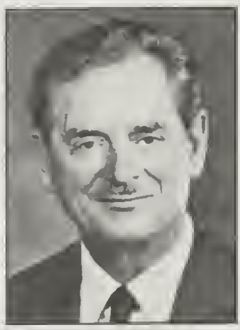
Swanson

Tomatis

Karen Thompson-Cardwell, MD, Henry Ford Hospital, and **Fritz P. Hoenke, MD**, Thunder Bay Community Health Services, have been awarded post-graduate fellowships by the College of Human Medicine, Michigan State University.... **W.E. Maldonado, MD**, senior vice president of Sparrow Hospital, Lansing, was advanced to Fellowship in the American College of Physician Executives.... **Paul R. Lichter, MD**, chairman of the Department of Ophthalmology and director of the Kellogg Eye Center at the University of Michigan Medical Center, is the new chairman of the American Board of Ophthalmology.... **Richard F. Nowak, MD**, Shepherd, recently was reappointed to the state Public Health Advisory Council for a term expiring May 30, 1990. ...The new officers of the Oakland County Medical Society are **Michael Garcia, MD**, Bloomfield Hills, president; **John A. Ingold, MD**, Royal Oak, president-elect; **Robert C. Arends, MD**, Troy, secretary; and **Paul D. Croissant, MD**, Rochester, treasurer... **E.J. Mueller, MD**, Birmingham, has been appointed to Beaumont Hospital's Board of Trustees. ...**Howard Brody, MD, PhD**, Coordinator of the MSU Medical Humanities Program, is chairman of the Medical Ethics Resource Network of Michigan steering committee which will oversee the set up and operations of the organization until its formal establishment in the spring of 1987.... **Alfred B. Swanson, MD**, Grand Rapids, was presented with a Michigan State Senate and House of Representatives Concurrent Resolution of Tribute in recognition of his scientific and international medical activities and humanitarian achievements.... **Luis A. Tomatis, MD**, Grand Rapids, has assumed the office of president of the Michigan Society of Thoracic Surgeons.... **Ken Hashimoto, MD**, a Wayne State University professor and chairman of the dermatology and syphilology department at WSU, is president-elect of the American Society of Dermatopathology. He also accepted an appointment to the Committee of Dermatologic Subspecialties of the American Academy of Dermatology.... **Pierre F. Giammanco, MD**, a facial plastic surgeon from Bloomfield Hills, and a Fellow of the American Academy of Facial Plastic and Reconstructive Surgery, will be a member of the faculty for the Academy's Western Region Meeting in Los Angeles.... **Phillip M. Green, MD**, Kalamazoo, recently received from the Michigan Gerontology Society the V.K. Volk award for his services to the elderly in Southwestern Michigan.... **George W. Morley, MD**, professor of obstetrics and gynecology at the University of Michigan Medical School, has been named the first Norman F. Miller Professor of Gynecology.... A milestone was reached for the College of Human Medicine, Michigan State University—the establishment of the first major endowed professorship, the Blanch B. and **Frederick C. Swartz** Endowed Professorship. The contribution has been established by Doctor and Mrs. Swartz for general internal medicine and for geriatric medicine within the Department of Medicine. Doctor and Mrs. Swartz are long time Lansing residents.... **Harvey V. Sparks, Jr., MD**, professor and chairman of the Department of Physiology at Michigan State University was recently awarded a Fullbright grant to lecture and do research in Zimbabwe.... **John B. Molidor, MD**, recently was named the new assistant dean and executive director for the Flint campus of MSU's College of Human Medicine. □

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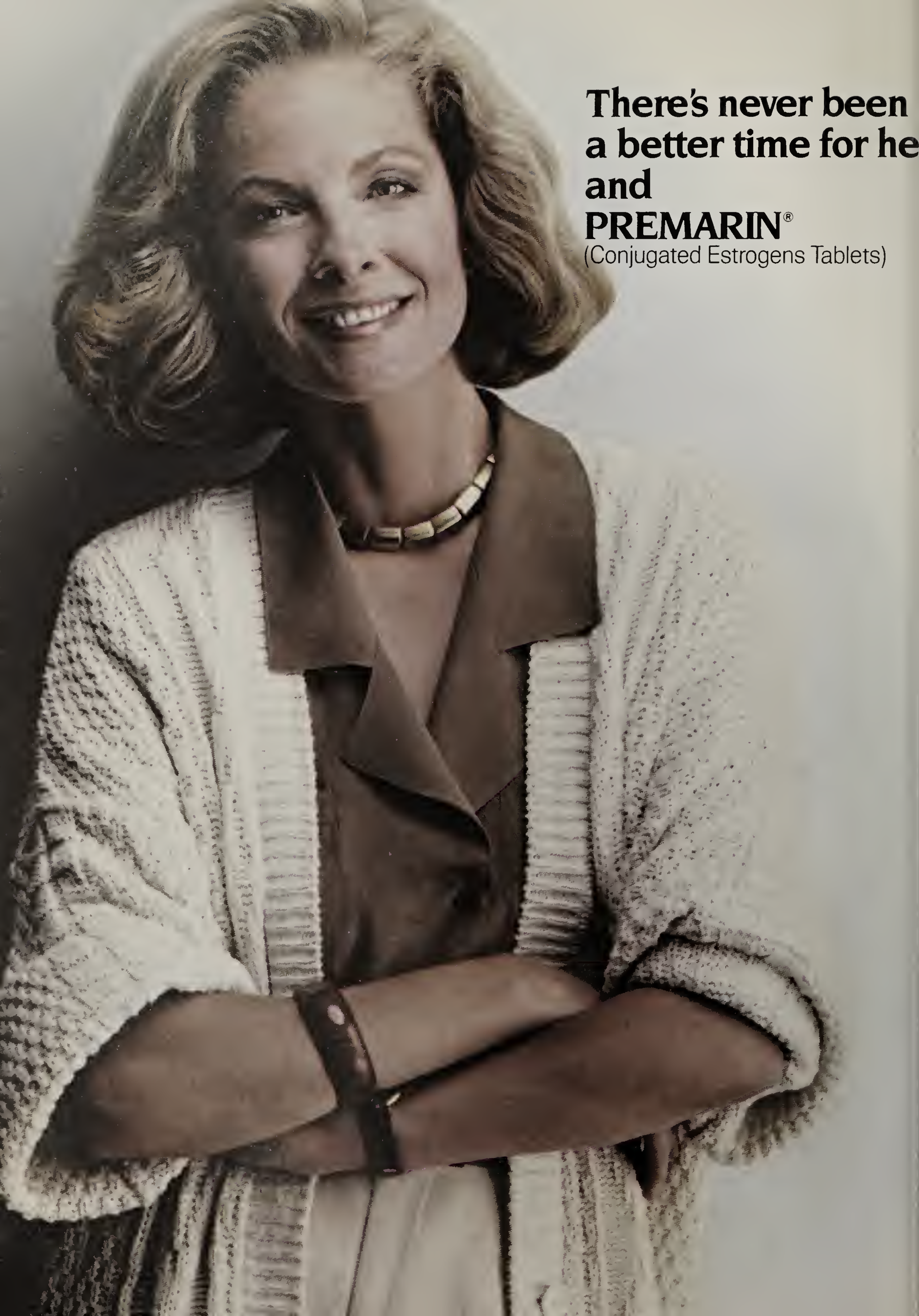
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0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

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For atrophic vaginitis

PREMARIN®

(Conjugated Estrogens)

Vaginal Cream

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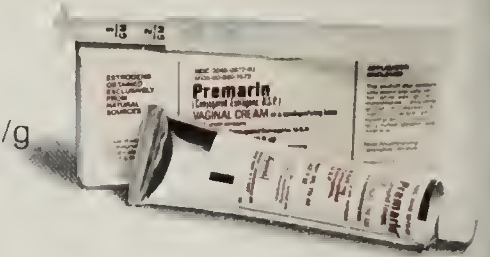

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13 9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2 ESTROGENS SHOULD NOT BE USED DURING PREGNANCY.

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix Although these changes are histologically benign, it is not known whether they are precursors of malignancy Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4 7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000 In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1 25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0 625 mg conjugated estrogens per gram

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions) **Osteoporosis (abnormally low bone mass)**. Atrophic vaginitis Kraurosis vulvae Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes Whether this will provide protection from endometrial carcinoma has not been clearly established There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2 Known or suspected estrogen-dependent neoplasia 3 Known or suspected pregnancy (See Boxed Warning). 4 Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders 6 A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated esfroge per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase t risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis When doses of this size a used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tendernes abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estroge containing oral contraceptives Increased blood pressure may occur with use of estrogens in the menopause a blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be careful observed Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to t initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organ and should include a Papanicolaou smear As a general rule, estrogen should not be prescribed for longer th one year without another physical examination being performed Conditions influenced by fluid retention such asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients m develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleedin mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the ri of endometrial hyperplasia in some patients Oral contraceptives appear to be associated with an increas incidence of mental depression. Patients with a history of depression should be carefully observed Preexistir uterine leiomyomata may increase in size during estrogen use The pathologist should be advised of estrog therapy when relevant specimens are submitted. If jaundice develops in any patient receiving esfrogen, t medication should be discontinued while the cause is investigated. Estrogens should be used with care in patien with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or young patients in whom bone growth is not complete If concomitant progestin therapy is used, potential risl may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

a Increased sulfobromophthalein retention

b Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3; increased no epinephrine-induced platelet aggregability

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting t elevated TBG; free T4 concentration is unaltered

d Impaired glucose tolerance.

e Decreased pregnanediol excretion

f Reduced response to metyrapone test.

g Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration As a general principle, the administration any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in huma milk

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptive breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea; premenstrual-like syndrom amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretio (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma whic may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migrain dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggrava tion of porphyria, edema, changes in libido

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atroph vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose th will control symptoms should be chosen and medication should be discontinued as promptly as possibl Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or tap medication should be made at three- to six-month intervals

2 *Given cyclically:* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically Adju upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level th will provide effective control. Osteoporosis —0.625 mg daily Administration should be cyclic (eg, three week on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measure taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued a promptly as possible

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer an appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurrin abnormal vaginal bleeding

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry an morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605 **2.** Paterson MEL, Wad Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in th climacteric. *Br Med J* 1980;280:822-824 **3.** Magos AL, Brincat M, Studd JWW, et al: Amenorrhea an endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obst Gynecol* 1985; 67: 496-499 **4.** Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulati in estrogen-treated postmenopausal women *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S Lobo RA Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesteron acetate treatment in postmenopausal women *Obstet Gynecol* 1985;66:216-219.

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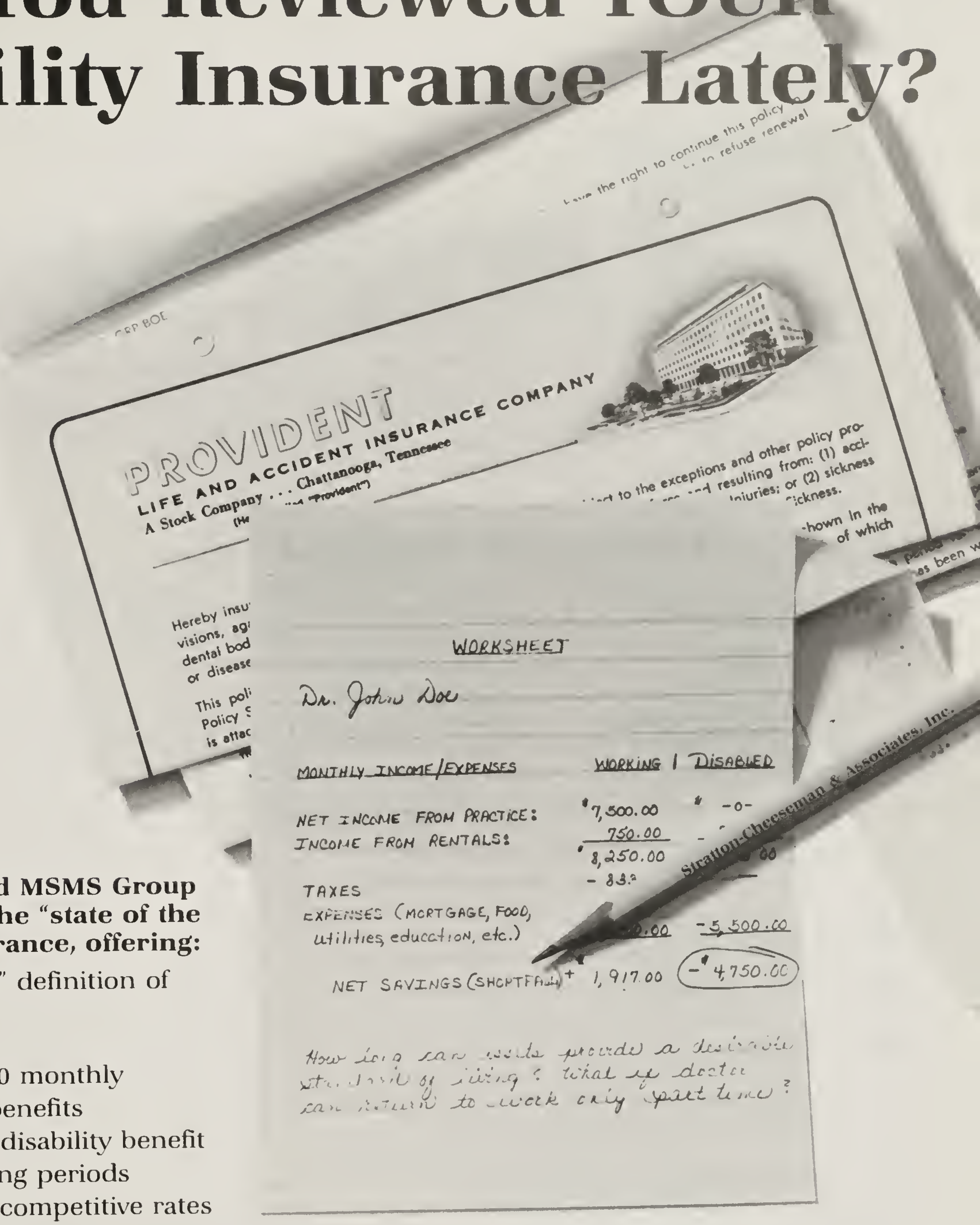

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STRATEGIES/Continued

the interests of the membership and the public; and provide visible evidence of the success of AMA's efforts on the members' behalf.

• *Issue management*—The provision of effective advocacy of the Association's policy positions in today's complex legislative and regulatory environment demands ever-increasing attention to the process of managing issues. Such a process involves the timely identification, analysis and prioritization of issues as well as the development of action plans clearly identifying the specific results that the Association wants to achieve.

• *Legislative strategy team*—The formulation of a legislative strategy team is a new AMA activity designed to impact on legislative issues and strengthen the Association's ability to achieve goals related to these issues.

• *Grassroots support activities*—Effective legislative results are based in many activities. One of vital importance is a strong grassroots activity designed to mobilize the membership at the local level and bring the individual views of physicians and others to bear on legislative issues. Through phonebanks, training seminars and on-site assistance organized and provided by the Association, the impact of organized medicine is greatly buttressed by increasing the number of voices carrying medicine's messages to the legislatures.

• *Health policy litigation*—The Office of the General Counsel will pursue to the Supreme Court, if necessary, AMA's challenge to the constitutionality of the Massachusetts mandatory assignment law. The Office will continue its aggressive health policy litigation activity in the Supreme Court and in other courts where fundamental values of the profession are at stake.

• *Professional liability coordination project*—In 1987, the AMA/National Medical Specialty Society Coordination Project will focus on designing and testing an alternative for resolving professional liability claims. Other project activities include the continuation of the clearinghouse function, the provision of definitive response to the critics of liability reform and the establishment of an information and education resource for risk management programs.

Achievement of greater public and professional understanding of the changing medical practice environment and the impact of such changes on the physician-patient relationship.

The Association's strong commitment to strengthen support for the profession by heightening public sensitivity to the changes taking place in the environment of medicine will continue in 1987 and beyond.

• *New strategic directions for the Association*—The broad organizational redirection includes

Continued on page 160

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Once the deductible amount has been met, Dimension III pays 80% and the subscriber pays a 20% copayment for covered health care services. When the subscriber has paid $1,000 in copayments, no further copayments are required. Dimension III pays 100% up to $1 million. And when you select one of these plans, you'll get all the benefits that characterize the best health care coverage available.

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Legislation needed to protect retirement plans

By Richard D. Weber

A major asset of a professional is often an interest in a qualified retirement plan. Self-employed persons or persons employed by relatively small partnerships or professional corporations, must financially plan for their retirement years. Such prudent planning, resulting from a lifetime of devoted attention to the practice of a profession, can be lost as a result of a single incident. The assets of a qualified retirement plan are not protected from judgement creditors under Michigan law.

This problem is most acute when applied to the medical profession. The current medical malpractice crisis subjects a physician's retirement plan to continuing jeopardy. Even if a physician can afford to pay the high premiums for malpractice coverage, limits in excess of $200,000 are generally unavailable. Under the current Michigan climate, malpractice verdicts often far exceed these limits. The Michigan State Medical Society proposed legislation to correct this problem.

Qualified retirement plans are subject to federal law, referred to as ERISA. ERISA preempts state law and prohibits the assignment or alienation of benefits provided by a qualified plan. Therefore, plans qualified under ERISA are protected against claims of judgement creditors except in egregious situations.

Under current Michigan law, a bankrupt professional has a devastating dilemma—there is no exemption for qualified retirement plans.

In the event of bankruptcy, however, the Bankruptcy Code prevails over ERISA to the extent these federal statutes are inconsistent. Under Bankruptcy Code Section 522(b)(2), a debtor may elect to exempt property exempted under applicable state law or under other federal law. Alternatively, the debtor may exempt certain property specified in Bankruptcy Code Section 522(d)(10)(E), which includes payments from a pension or profit sharing plan. Although ERISA is federal law which protects assets from alienation, courts have generally held that ERISA is not included within "other federal law" contemplated in the Bankruptcy Code. This leaves the bankrupt professional with the exemptions available for certain limited classes of property, including payments from qualified retirement plans, available under the Bankruptcy Code, or, alternatively, exemptions available under state law.

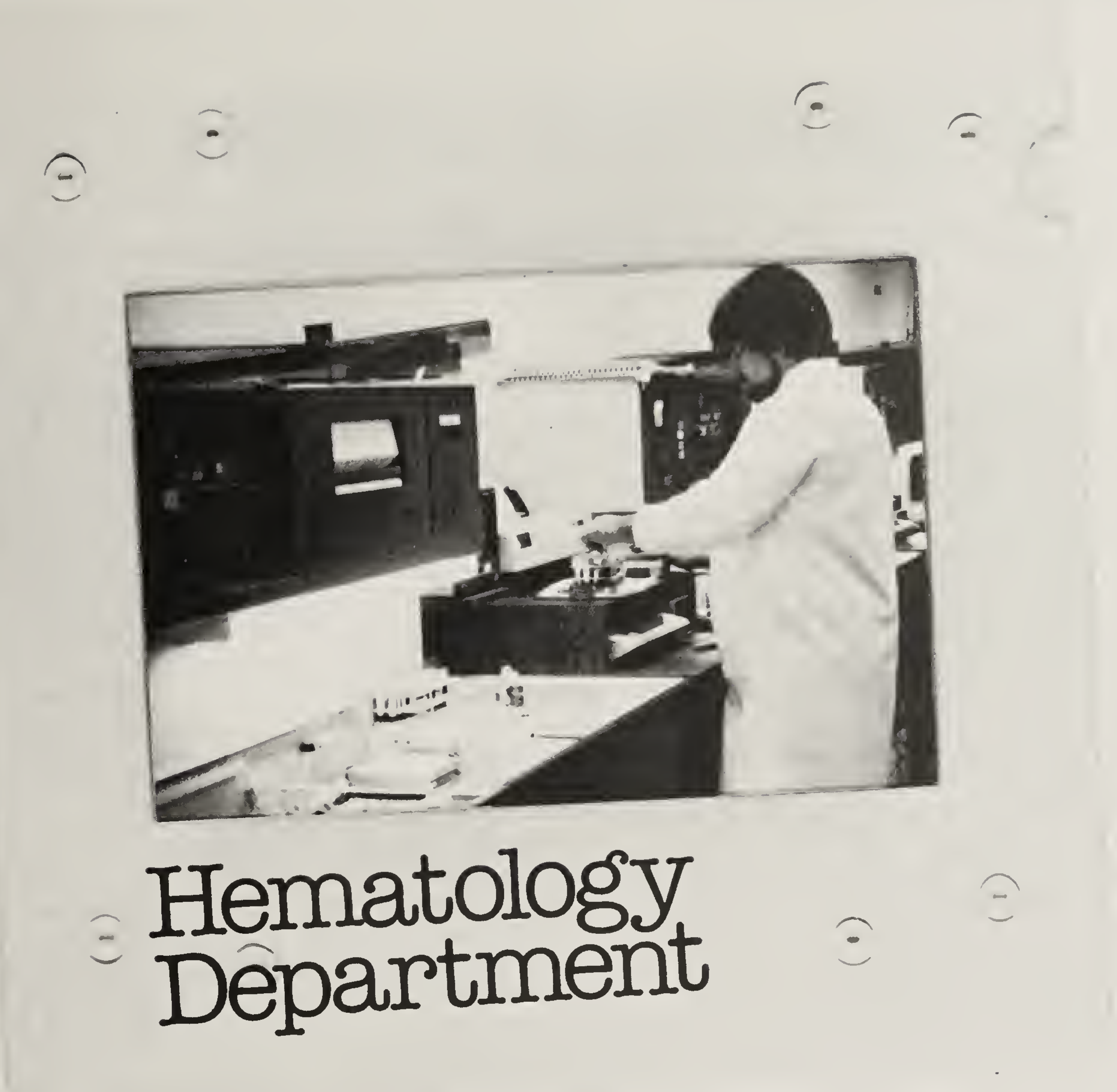
Under current Michigan law, a bankrupt professional has a devastating dilemma. There is no exemption for qualified retirement plans; but there are a number of other exemptions, the most important of which is probably the jointly held property exemption. A bankrupt professional in Michigan is therefore confronted with the dilemma of either protecting jointly held property (which probably includes the home) or retirement plan assets. This was the dilemma confronting Doctor LaFata, a Michigan physician in *LaFata, MD* vs. *Weber/USDC* No. 84-CV-4308-DT (1985). Doctor LaFata, the victim of a large malpractice judgement without insurance, elected his Michigan exemptions to protect his jointly held property, and lost his retirement plan in bankruptcy.

With an addition of an appropriate exemption to the Michigan law, a Michigan physician would not jeopardize his retirement plan assets every time he treats a patient. Legislation to this end currently is being drafted by Senator Dan DeGrow (R-Port Huron) who was the lead actor in last year's liability tort reform efforts. Senator DeGrow currently serves on the Judiciary Committee.

With new legislation and under current case law, a physician who is placed into bankruptcy, either voluntarily or involuntarily, would elect state exemptions and protect his jointly held property and retirement plan assets. This would be consistent with other federal law and would also place the professional

Continued on page 160

The author, Mr. Weber, is MSMS legal counsel with the law firm Kerr, Russell and Weber, Detroit.



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STRATEGIES/Continued

initiatives in the health policy, scientific, educational, marketing and administrative areas, all of which are aimed at strengthening AMA's ability to increase its visibility and credibility among the profession and the public.

- *Communications activities*—The Association maintains a strong, fundamental communications program and assists Federation units in attaining this same objective. Key activities within this program include media relations, consulting services, communications research and the editorial visitation activity.
- *1987 national public awareness campaign*—The 1987 National Public Awareness Campaign has been designed to complement AMA's on-going activities by including a number of exciting, new communications initiatives to build strong public support for medicine. Of particular significance is the broader use of television as a major communications tool including video news releases, special events broadcasting, teleconferencing and the continued exploration of a syndicated television program on health issues. Communications will be directed to both physicians and the public.

Demonstration of the role of physicians as patient advocates by the expanded provision of information related to personal health.

Over the past several years, the House of Delegates has demonstrated strong interest in informing the public of how the environment of medicine has changed and what those changes mean in terms of patient relationships with physicians. However, it is equally important that information related solely to personal health be heard from physicians and physician organizations so that a message of patient advocacy is heard as well.

- *Public health messages*—A key component of the 1987 National Public Awareness Campaign will be to focus on a public health message, and the theme for 1987 will be the dangers of tobacco smoking. The Association has a strong track record on smoking issues, including adopting policy that would establish a smoke-free society by the year 2000 and calling for a ban on the advertising of tobacco products.
- *Adolescent health activities*—Drawing upon broad-based Association expertise, *AMA's White Paper on Adolescent Health* is a well-documented report outlining specific actions that can be taken by organized medicine and individual physicians alike to address the pressing health concerns related to America's youth. This major Association initiative is expected to bring the public and physicians together in significant efforts to control drug and alcohol abuse, lessen the frequency of suicide, reduce early pregnancy and infant mortality and address mental health concerns related to adolescence.
- *AIDS information*—Providing educational assistance to physicians to enable them to provide scientifically based information on AIDS to the public will continue to be a high priority activity for the Association in 1987.

Increased provision of information to support physician learning and improve the practice of medicine.

If the AMA is to satisfy the needs of most physicians and do this throughout the course of their lives, it must find some common denominator that cuts across medical specialty, type of practice, geographic area, age and gender. The AMA's new key objective suggests that this common thread is knowledge, and that the principal benefit the Association can provide is to develop and distribute information of proven usefulness to physicians throughout their years in practice and beyond.

- *Scientific publications*—As part of the AMA's scientific information program, the *Journal of the American Medical Associa-*

Continued on page 17

RETIREMENT/Continued

on the same level as other Michigan citizens. Under separate statutes, exemptions are provided for retirement benefits of judges, legislators, municipal employees and state employees. ☐

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Malpractice or unwanted results?

By Charles C. Vincent, MD

Michigan physicians are allowed the privilege to practice medicine under the State Public Health Code. The activities of the legislatively-appointed Board of Medicine are to protect public health, safety and welfare, to discipline doctors for incompetence, substance abuse (our most common offense), mental incompetence and mental or physical inability to practice.

Of the many charges our Board has been given, considerable time and effort are devoted to the issues of incompetence and medical malpractice. We have been unable thus far to define a direct relationship between these two issues. Is the doctor with multiple malpractice suits practicing below acceptable standards or are other variables leading to unwanted results? It is known that a majority of the malpractice claims are against a few physicians in identified specialties:

- 2.5 percent (625) of all physicians accounted for 19.7 percent of all medical malpractice claims.
- 19.3 percent (4,825) of all physicians accounted for 72.2 percent of all medical malpractice claims.
- 58.1 percent of Michigan's doctors had no medical malpractice claims against them.

Having been on this Board since 1982, I can recall only three instances where administrative complaints registered by citizens of our state were presented to the Board of Medicine for action allegedly secondary to medical malpractice. It is my impression that many of our more vocal state legislators view this inactivity as a lack of action by our Board.

Of the many charges our Board has been given, considerable time and effort are devoted to the issues of incompetence and medical malpractice.

Doctor Vincent

Following our "March on Lansing" in 1985, some changes in the Public Health Code require the Board of Medicine to investigate doctors with:

1. A total of three or more medical malpractice settlements, judgments or awards against them in a 10 year period.
2. One or more malpractice settlements, awards or judgments against a licensee totaling more than $200,000 in any consecutive 10 year period.

Total investigations per this mandate are as follows:

	1984	1985	1986
$100,000 or over	76	110	97
$200,000 or over	18	30	28

With additional funding and a computerized data collection system, the Bureau of Health Services is establishing a process to enforce this mandate. One major problem is the settlement clause prohibiting further action against a physician defendant.

It is the Board of Medicine's responsibility to investigate and discipline physicians who do not practice at an acceptable standard. But, it is my belief that results will demonstrate that excellent care is rendered by Michigan doctors and that most malpractice claims are based simply on unwanted results. ☐

The author, Doctor Vincent, is chairman of the Michigan Board of Medicine.

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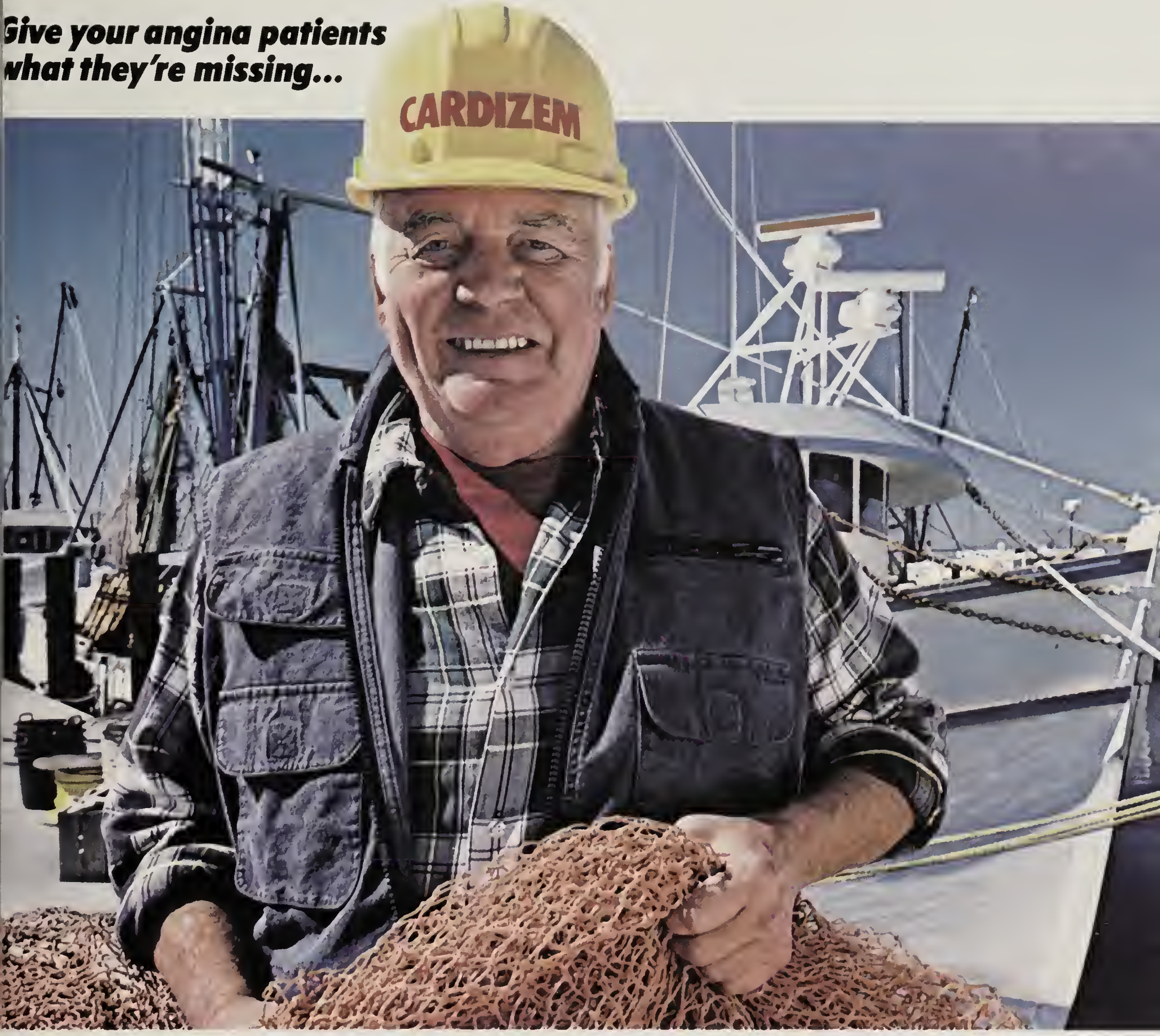

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***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.

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Brief Summary
Professional Use Information

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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%).

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

See complete Professional Use Information before prescribing

References: 1. Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983; 106(6):1341-1347 **2.** Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159 **3.** Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985;55:680-687. **4.** Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed). Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39 **5.** Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982;50(Sept):94-116.

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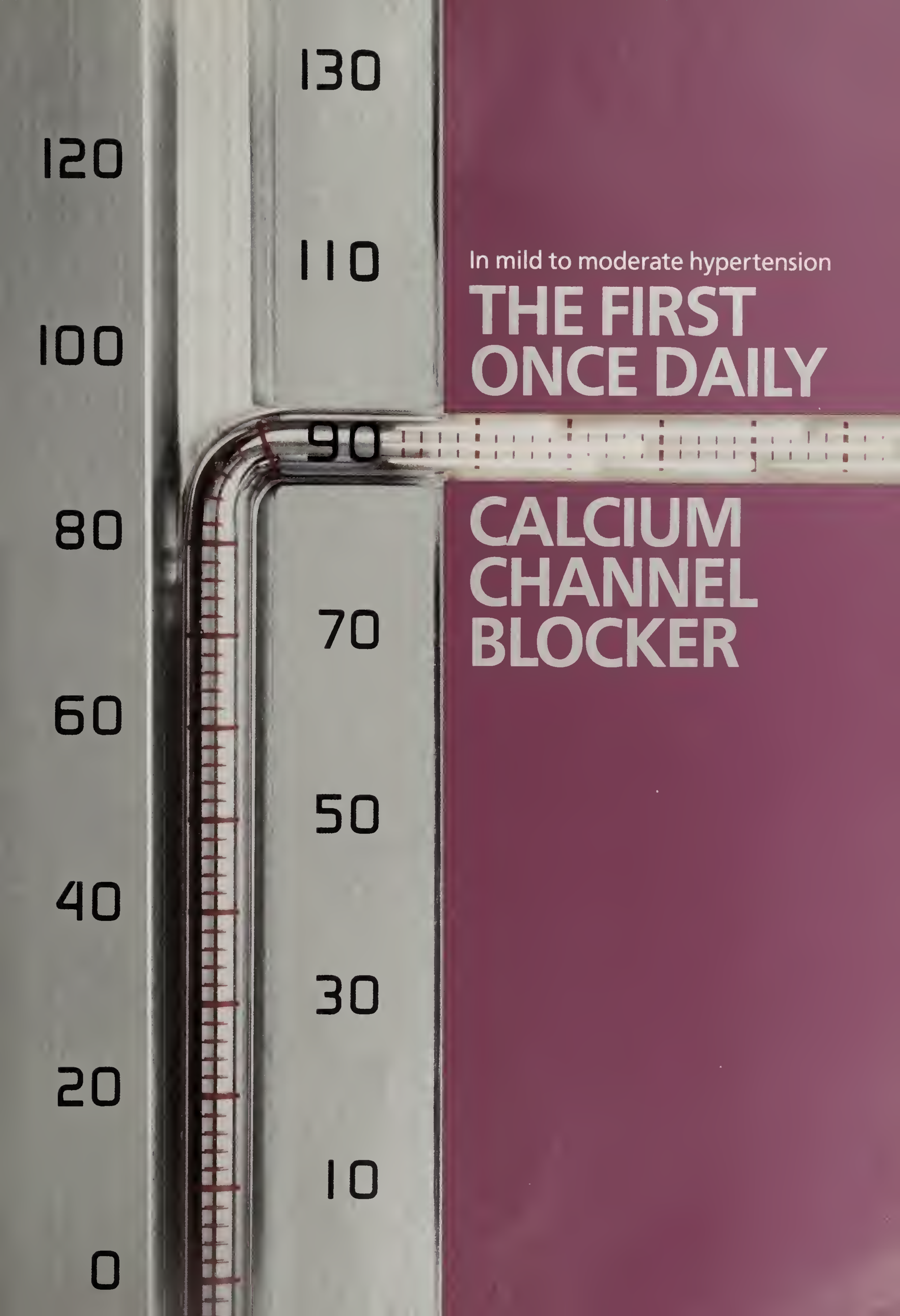
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In mild to moderate hypertension
THE FIRST ONCE DAILY
CALCIUM CHANNEL BLOCKER

NEW
ONCE DAILY

ISOPTIN SR*

(verapamil HCl/Knoll)

240 mg scored, sustained-release tablets

JAMES B.
38, black male, heavy smoker. Prescribed a diuretic by another physician last year for hypertension.

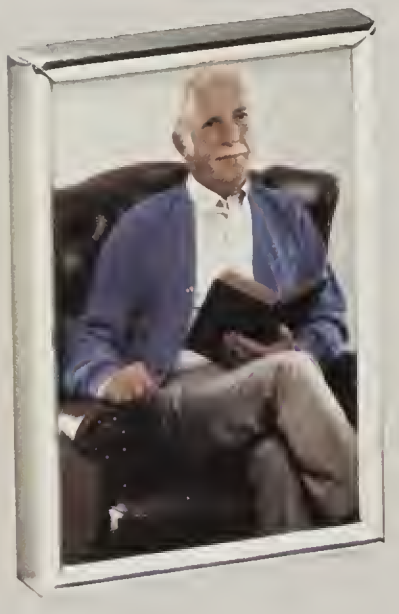
YOUR CONCERNS
Presents with "smoker's cough." Workup reveals a BP of 150/107.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN® (verapamil HCl/Knoll) because...
- Black hypertensives often have low plasma renin activity and generally do not respond favorably to beta blockers.
- Beta blockers may increase the likelihood of bronchospasm.

ALICE W.
65, diabetic, overweight. Her BP has elevated to 190/98.

YOUR CONCERNS
She's on daily insulin.

A LOGICAL CHOICE FOR CONTROL OF HER BP
ISOPTIN® (verapamil HCl/Knoll) because...
- Unlike most beta blockers and diuretics, ISOPTIN has no adverse effects on serum glucose levels.
- Unlike most beta blockers, ISOPTIN does not mask the symptoms of hypoglycemia.



THOMAS G.
70, asthmatic. In the past, BP adequately controlled with 25 mg hydrochlorothiazide daily.

YOUR CONCERNS
Today patient presents with symptoms of gout. Workup reveals high uric acid level, low serum potassium, and BP elevated to 180/98.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN® (verapamil HCl/Knoll) because...
- Unlike diuretics, ISOPTIN will not decrease serum potassium levels or elevate uric acid levels.
- Unlike beta blockers, ISOPTIN can be used safely in asthma and COPD patients.

JOHN K.
42, Annual physical uncovered diastolic BP of 102... confirmed on three successive office visits. Unresponsive to nonpharmacologic intervention.

YOUR CONCERNS
Salesman, spends many hours of his working day in car... total cholesterol level 300, HDL 35.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN® (verapamil HCl/Knoll) because...
- Unlike diuretics, ISOPTIN does not cause urinary urgency.
- Unlike either beta blockers or diuretics, ISOPTIN will not adversely affect his already seriously compromised lipid profile.
- Unlike with propranolol, fatigue and impotence are rarely reported.

Antihypertensive therapy you and your patients can live with

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In mild to moderate hypertension Brief Summary

THE FIRST ONCE DAILY CALCIUM CHANNEL BLOCKER

ISOPTIN® SR
(verapamil HCl/Knoll)
240 mg scored, sustained-release tablets

CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome or 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker).

WARNINGS: Heart Failure: ISOPTIN should be avoided in patients with severe left ventricular dysfunction (see DRUG INTERACTIONS). Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. Hypotension: ISOPTIN (verapamil HCl) may produce occasional symptomatic hypotension. Elevated Liver Enzymes: Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. Accessory Bypass Tract (Wolff-Parkinson-White): Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed ncreased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk. Treatment is usually D.C.-cardioversion. Atrioventricular Block: The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare nstances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy (IHSS): Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIONS: Impaired Hepatic or Renal Function: Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted in the urine. In patients with impaired hepatic or renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see OVERDOSAGE).

Drug Interactions: Beta Blockers: Concomitant use of ISOPTIN and oral beta-adrenergic blocking agents may be beneficial in certain patients with chronic stable angina or hypertension, but available information is not sufficient to predict with confidence the effects of concurrent treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities. Digitalis: Clinical use of verapamil in digitalized patients has shown the combination to be well tolerated if digoxin doses are properly adjusted. However, chronic verapamil treatment increases serum digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISOPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. Antihypertensive Agents: Verapamil administered concomitantly with oral antihypertensive agents (e.g , vasodilators, angiotensin-converting enzyme inhibitors, diuretics, beta blockers, prazosin) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored Disopyramide: Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. Ouinidine: In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine resulted in significant hypotension. There has been a report of increased quinidine levels during verapamil therapy Nitrates: The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. Cimetidine: Two clinical trials have shown a lack of significant verapamil interaction with cimetidine. A third study showed cimetidine reduced verapamil clearance and increased elimination to 1/2. Anesthetic Agents: Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. Carbamazepine: Verapamil may increase carbamazepine concentrations during combined therapy. Rifampin: Therapy with rifampin may markedly reduce oral verapamil bioavailability. Lithium: Verapamil may lower lithium levels in patient on chronic oral lithium therapy. Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show mpaired fertility. Effects on male fertility have not been determined. Pregnancy (Category C): There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery This drug should be used during pregnancy, labor, and delivery, only if clearly needed. Nursing Mothers: ISOPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. Pediatric Use: Safety and efficacy of ISOPTIN in children below the age of 18 years have not been established.

ADVERSE REACTIONS: Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, edema 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, 3° AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following reactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the physician to a possible relationship: angina pectoris, arthralgia and rash, AV block, blurred vision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, dyspnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, gingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, nsomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic symptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, syncope, urticaria. Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe hypotension or complete AV block occur following oral administration of verapamil, the appropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium gluconate (10% solution). If further support is necessary, inotropic agents (dopamine or dobutamine) may be administered. Actual treatment and dosage should depend on the severity and the clinical situation and the judgment and experience of the treating physician.

OVERDOSAGE: Treatment of overdosage should be supportive. Beta-adrenergic stimulation or parenteral administration of calcium solutions may increase calcium ion flux across the slow channel, and have been used effectively in treatment of deliberate overdosage with verapamil. Clinically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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WSU medical research facility

The Wayne State University School of Medicine has received three major grants totaling $3 million in recent weeks to support construction of a new medical research building to be located within the Detroit Medical Center (DMC) campus. The awards include: $1.5 million from The Kresge Foundation, $1 million from The Skillman Foundation, and $500,000 from The Hudson-Webber Foundation.

The grants add significantly to the base of funding established last December through a $2 million gift from the Louis M. and Mollie Elliman Foundation, $1.5 million of which was dedicated to initiate the building project.

"These generous gifts will greatly enhance the School of Medicine's mission to provide the superior health care, education and research that characterize a preeminent medical center," stated Henry L. Nadler, MD, Dean of the School of Medicine. "I am grateful to these charitable organizations who, through their combined support, have made an investment in the future vitality of the city."

The 100,000 square-feet Louis M. Elliman research building, to be named for its primary benefactor, will provide the much-needed space and facilities vital to conducting productive research, which in turn will enable the School of Medicine to attract outstanding physicians and scientists.

Construction of the new building will commence at the corner of Canfield and Brush early next spring and will cost an estimated $15 million before its scheduled completion in June 1988.

Affordable health care program receives grant

The Southeastern Michigan Program for Affordable Health Care (SEMPAHC) has received a grant of $269,500 from The Robert Wood Johnson Foundation. The program is administered by the Greater Detroit Area Health Council (GDAHC).

The goal of SEMPAHC is to reduce the rate of health care cost escalation by reducing and redirecting the use of and demand for health care services and making corresponding changes in supply. Under the auspices of SEMPAHC, more than 30 co-sponsoring organizations, including employers, labor organizations, health care providers, insurers, government agencies and community groups, work together to develop innovative approaches aimed at making quality health care accessible and affordable.

SEMPAHC funds will be used to support a variety of demonstration projects. One of the projects currently under development is the establishment of the Detroit Geriatric Health Clinic with Henry Ford Hospital. Mount Carmel Mercy Hospital will also be participating in this endeavor. The clinic will provide low income elderly with preventive and maintenance health care services. It will be located in the Rosa Parks, Durfie and Russell Woods area which has a population of 13,000 people over 65 years of age. Approximately 21 percent of this elderly population is below the poverty level. The two sponsoring hospitals will also work with the Michigan Medicaid program to explore new methods of paying for services for the low income elderly population.

In addition, the grant will assist in the continued funding of two existing SEMPAHC projects: The Older Adults Social/Health Maintenance Organization (Social/HMO) Demonstration Project and the Program for Health in Business.

The Program for Health in Business is designed to demonstrate that an integrated and comprehensive worksite health management program can effectively improve employees' health and reduce health care costs paid by small and medium sized employers. Oakwood Hospital, Dearborn and Sinai Hospital, Detroit, are cooperating in this effort.

John F. Fennessey, MD, and Walter G. Parker, MD, serve on the committee governing SEMPAHC. □

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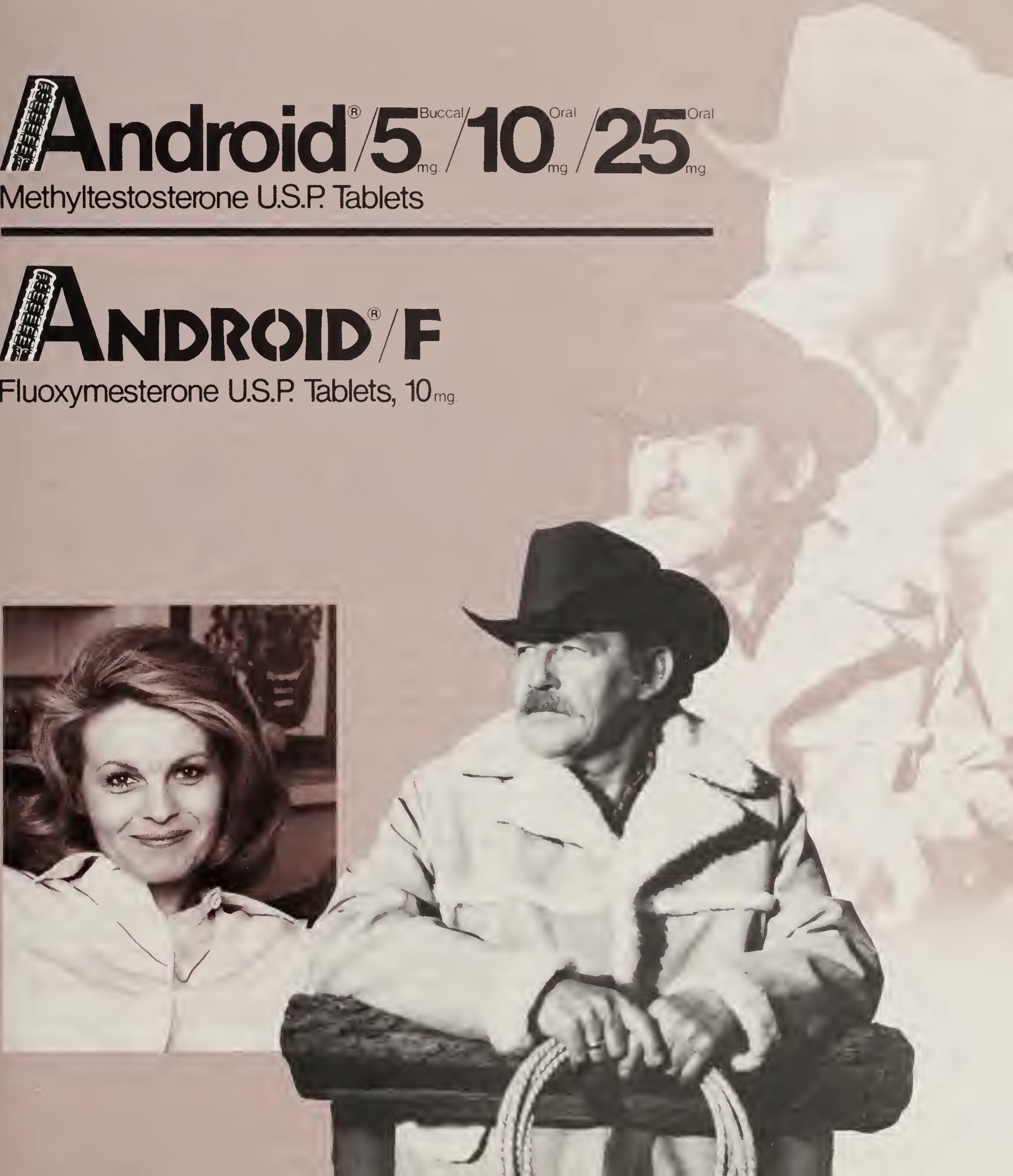

tion (JAMA) and the AMA's specialty journals are published to keep the world's largest audience of generalists and specialists up-to-date on matters relevant to the practice of medicine.

- *Socioeconomic publications — American Medical News (AM News)* continues to serve as the national newspaper of medicine and as a premier information resource to the profession by reporting on major news stories affecting medicine; by providing supporting feature stories that enhance understanding and sharpen perspective for news events; and by displaying and supporting Association policy. In 1987, a new weekly business section will be established for *AM News* to address physician needs on the business side of medicine and to broaden advertising support for the publication.
- *Scientific activities*—Strong, continuing emphasis will be placed on the Association's scientific activities to provide a current and reliable source of factual information for the practicing physician.
- *Practice development initiatives*—A number of new initiatives will be undertaken in 1987 to assist physicians in remaining competitive in a changing medical practice environment. These include the development of an expanded array of practice management products and services; the establishment of a clearinghouse of information and evaluation resources on medical delivery systems; and an analysis of AMA's role in assisting physicians in evaluating or negotiating contracts with employers, joint ventures or payment systems.

Achievement of stronger Association influence and support in the medical education and scientific communities.

In 1986, a sustained effort was begun to involve the medical education and scientific communities in AMA activities and to establish the AMA as a policy leader in education and science.

- *Education and science outreach activities*—Key projects designed to enhance communications between the AMA and the medical education community include the medical school visitation activity, the electronic bulletin board project and a rejuvenated Section on medical schools. In addition, the commonality of problems and interests among AMA, educators and scientists will be demonstrated and pursued through research projects of mutual interest, liaison activities, financial support through direct and in direct AMA-ERF grants and fun raising.

Expansion of AMA membership through the increased retention of existing members and th attraction of new members, wit particular focus on selected segments of the physician population.

The Association's new strategi directions are based on the underlying premise that, in order t be credible, the AMA needs th active support of a significan majority of physicians as well a high levels of public trust an confidence. To obtain this support, the Association must offe services to its members not available from other sources, or a least not available on terms as attractive as those of the Association.

- *Strategic membershi plan*—An Association-wid Strategic Membership Plan wil be developed and implemente in 1987 to provide increase levels of focus and coordinatio among AMA activities that directly or indirectly impact o AMA membership recruitment o retention.
- *Target segment surveys*—Surveys will be conducted durin 1987 among selected segments o the physician population t determine the factors that shap AMA membership decision within these targeted groups.

Continued on page 18

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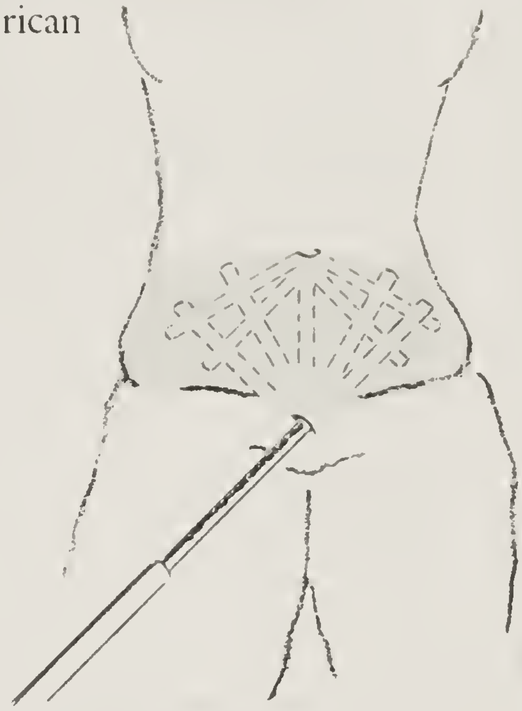

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ranitidine HCl/Glaxo 150 mg tablets

EFFECTIVE MAINTENANCE THERAPY

for healed duodenal ulcer patients

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In two randomized, double-blind, and well-controlled clinical trials, ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

Percent of patients with observed duodenal ulcer recurrence

		0-4 months	0-8 months	0-12 months	No. patients
USA[1]	ranitidine 150 mg h.s.	9%	14%*	16%†	60
	cimetidine 400 mg h.s.	23%	34%	43%	66
UK, Ireland, Australia[2]	ranitidine 150 mg h.s.	8%‡	14%‡	23%‡	243
	cimetidine 400 mg h.s.	21%	34%	37%	241

*p=0.02
†p=0.01
‡p≤0.004
%=life-table estimates
All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Convenient once-a-night dose with a low incidence of side effects[3]

Headache, sometimes severe, seems to be related to ranitidine administration. Other side effects have been reported; for a complete listing, see the **ADVERSE REACTIONS** section in the Brief Summary.

No significant interference with the hepatic cytochrome P-450 enzyme system at recommended doses

ZANTAC 150 mg has no significant drug interactions with theophylline, phenytoin, or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications that decrease gastric acidity are administered.

Zantac® 150
ranitidine HCl/Glaxo *150 mg tablets*

One tablet at bedtime
for maintenance

See next page for references and
Brief Summary of Product Information.

Glaxo/ROCHE®

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Zantac® 150

ranitidine HCl/Glaxo 150 mg tablets

One tablet at bedtime for maintenance therapy in healed duodenal ulcer patients

References:

1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.
3. Data available on request, Glaxo Inc.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

The following is a brief summary only. Before prescribing, see complete prescribing information in ZANTAC® product labeling.

INDICATIONS AND USAGE: ZANTAC® is indicated in:

1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Although recommended doses of ZANTAC do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Lack of experience to date precludes recommending ZANTAC for use in children or pregnant patients. Since ZANTAC is secreted in human milk, caution should be exercised when administered to a nursing mother.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to ZANTAC® administration. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

There have been rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION. Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

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Souren L. Chamichian, MD
Mount Pleasant

Doctor Chamichian died October 26 at the age of 71. He was born in Aintab, Turkey in 1915. Doctor Chamichian received his medical degree from the American University of Beirut in 1939. He did research at the New York Ear and Eye Infirmary. Doctor Chamichian had been as an opthalmologist in Mt. Pleasant since 1951.

Henry W. Clapp, MD
Sun City, Arizona

Doctor Clapp, formerly of Muskegon, died November 11, 1986, at the age of 79. He received his bachelors degree in 1929 from Michigan State University and his medical degree in 1933 from the University of Michigan. He specialized in obstetrics and gynecology and was an intern at Harper Hospital. Doctor Clapp served in the US Air Force from 1942 to 1946.

Robert L. Fransway, MD
Ann Arbor

Doctor Fransway died December 7, 1986, at the age of 64. He was a graduate of the University of Wisconsin Medical School and he specialized in psychiatry at the University of Michigan. He completed his internship at Mercy Hospital in Des Moines, Iowa, in 1952. Doctor Fransway was a resident pathologist at St. Joseph Hospital in Milwaukee and a resi-

Continued on page 180

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dent psychiatrist at Northville State Hospital. He was on the staff at Mercywood and St. Joseph hospitals at the time of his death and was former chief of staff at Mercywood Hospital.

Shattuck W. Hartwell, MD
Chagrin Falls, Ohio

Doctor Hartwell, formerly of Muskegon, died November 14, 1986, at the age of 86. He received his medical degree in 1926, his MSc in surgery in 1929, and PhD in surgery in 1930 from the University of Minnesota Medical School. Doctor Hartwell enlisted in World War I in 1918 and volunteered in World War II serving in New Guinea and Manila. He also was author of the book *The Mechanisms of Healing in Human Wounds*, published in 1955.

John J. Kowaleski, MD
Southgate

Doctor Kowaleski died December 15, 1986, at the age of 59. He was a graduate of Wayne State University College of Medicine. He served his internship at Detroit Memorial Hospital and did post-graduate work at the University of Michigan, University of Colorado School of Medicine and the University of Kentucky. He was a family practitioner. Doctor Kowaleski was a US Army veteran of World War II who served in the office of fiscal director in Europe.

Lee A. Lewis, MD
Grosse Pointe Farms

Doctor Lewis died January 2, 1987, at the age of 80. He was a clinic physician at Doctors Hospital for more than 51 years and former chief of staff. He was Phi Beta Kappa at the University of Michigan, where he earned a bachelor's degree, medical degree and master of science in surgery. Doctor Lewis also was an instructor in surgery at the University of Michigan and Wayne State University.

Wilbur C. Martin, MD
Detroit

Doctor Martin died January 6, 1987, at the age of 74. He earned a bachelor's degree from Morehouse College in 1935 and completed his medical studies in 1940 at the Meharry College of Medicine in Nashville. He was former chief of staff at Burton Mercy Hospital. During World War II, Doctor Martin served as a physician in the US Army.

Arthur J. Tesseine, MD
Grand Rapids

Doctor Tesseine died December 21, 1986, at the age of 78. He received his medical degree from the St. Louis Medical School in 1932. He was in general practice in Grand Rapids until 1968 at which time he became medical director at the Michigan Veterans Facility. Doctor Tesseine served in World War II as a captain in the US Army Medical Corps.

John Vroon, MD
Jenison

Doctor Vroon died December 12, 1986, at the age of 75. He received his medical degree from the University of Michigan in 1940. Following postgraduate work he served a medical missionary until 1956. He was in practice in Grand Rapids as a general surgeon in between many medical missions to India, Pakistan, Nigeria and Ethiopia. ☐

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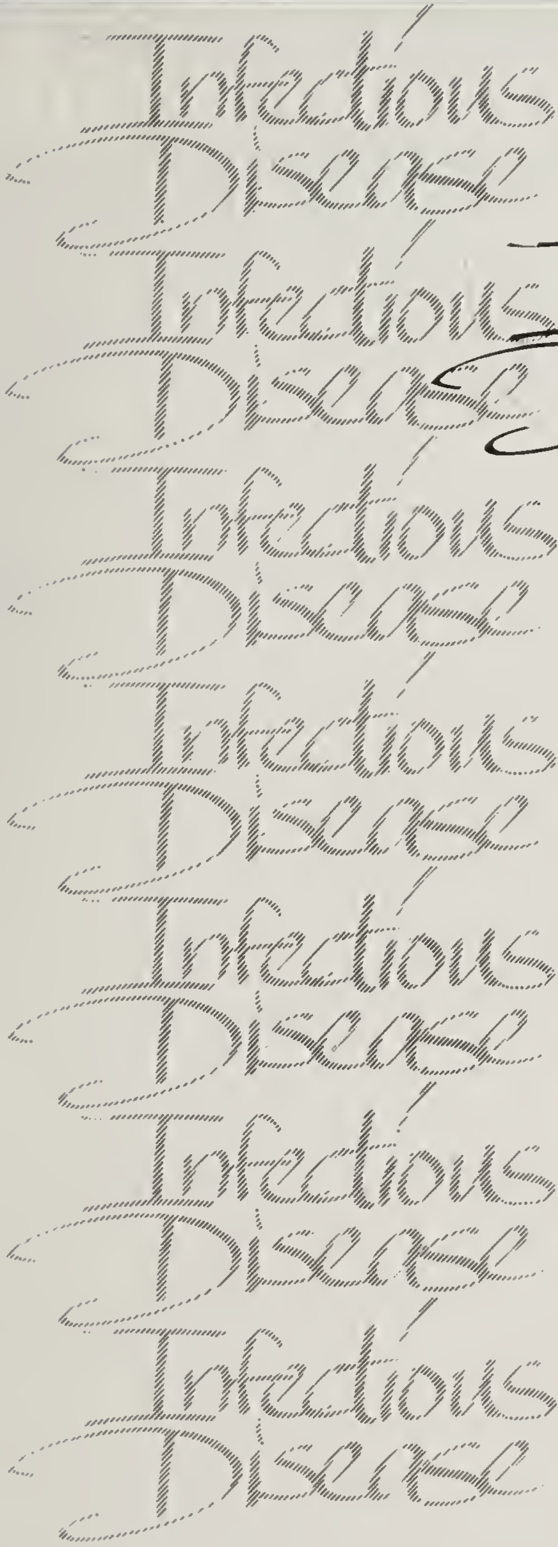

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  Stanley Gall, MD, Professor and Associate Head of Department of OB/GYN, Director, Division of Maternal and Fetal Medicine - University of Chicago
- **"The New Infectious Diseases of the 1980s"**
  Robert Fekety, MD, Professor of Internal Medicine - University of Michigan
- **"Pathogenesis of Peritonitis"**
  Richard Simmons, MD, Professor of Surgery and Microbiology, Chief of Surgical Infectious Disease Service - University of Minnesota
- **"Pneumonia: Practical Approaches to Diagnosis and Treatment"**
  Carl B. Lauter, MD, Chief of Medical Services, William Beaumont Hospital, Associate Clinical Professor of Medicine - Wayne State University School of Medicine
- **"Odontogenic Infections"**
  Lawrence J. Marentette, MD, Assistant Professor of Otolaryngology - University of Minnesota
- **"Health Information for International Travelers"**
  Jeffrey Band, MD, Corporate Epidemiologist, Chief of Infectious Diseases - William Beaumont Hospital
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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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1735 Maybrook Rd.
Jackson 49203

Jeneen S. Almdale, MD —PD
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Wyoming 49509

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6879 Vista Grande Dr.
Rockford 49341

Sultan M. Bhimani, MD —R/DR
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Flint 48504

B. Douglas Campbell, MD —N
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Douglas J. Coles, MD —FP
224 Park Ave. Box 2188
Frankford 49635

Chafik N.Dakak, MD —PD
211 S. Crapo
Mt. Pleasant 48858

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3340 Hospital Rd. Box 2089
Saginaw 48605

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Marquette 49855

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STRATEGIES/Continued

- *Membership Acquisition and Retention System (MARS)*—This sophisticated computer system was designed in 1986 to facilitate the storage and retrieval of historical and current membership information on individual physicians.

More effective application of marketing techniques to ensure that Association products and services meet identified needs in a manner that denies duplication and deters competition.

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- *New marketing position*—To ensure that the Association's marketing function receives a high level of visibility and support throughout the AMA, a new position entitled Vice President, Marketing, will be established.
- *Comprehensive marketing plan*—The development and implementation of a comprehensive marketing plan for the Association will establish a framework for analyzing market opportunities; researching and selecting target markets; developing marketing strategies consistent with Association strategies; planning

Continued on page 186

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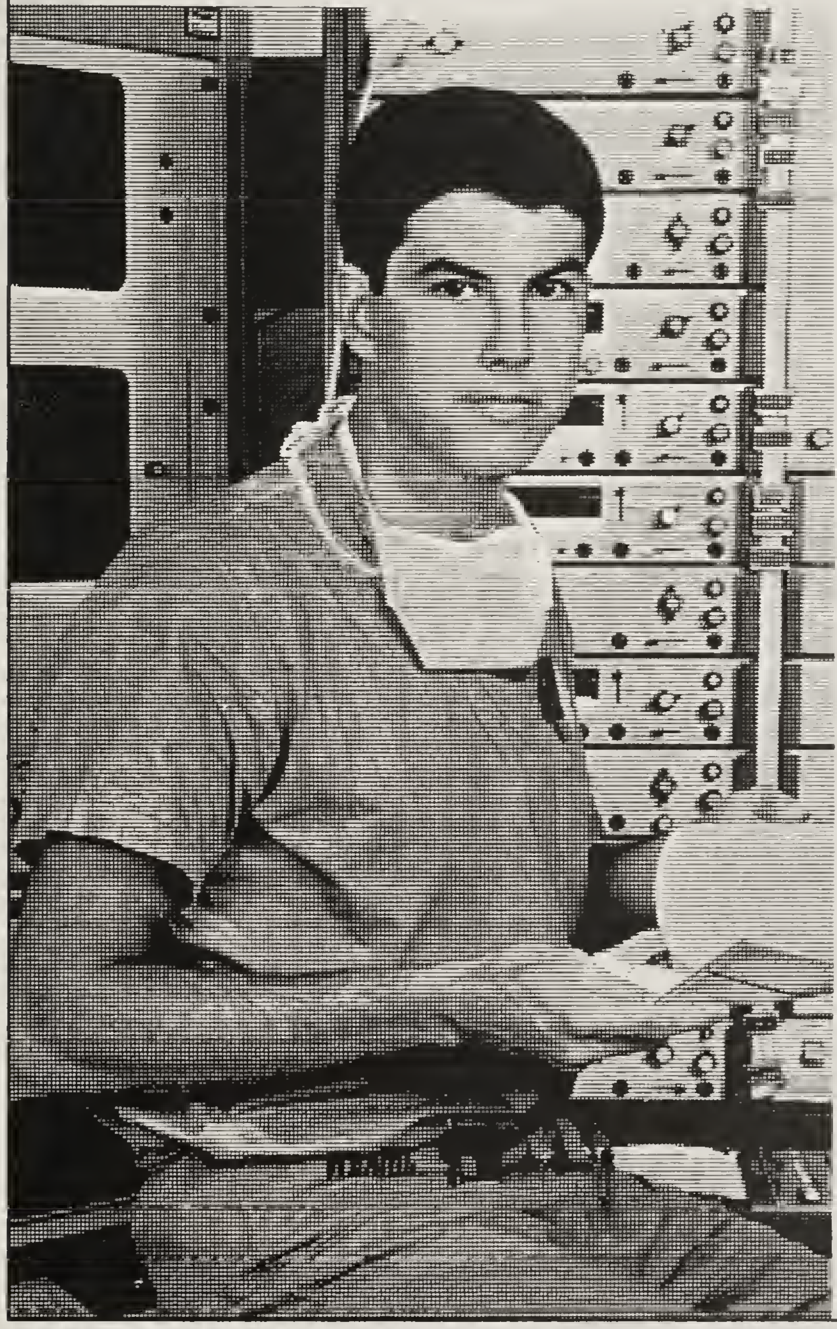

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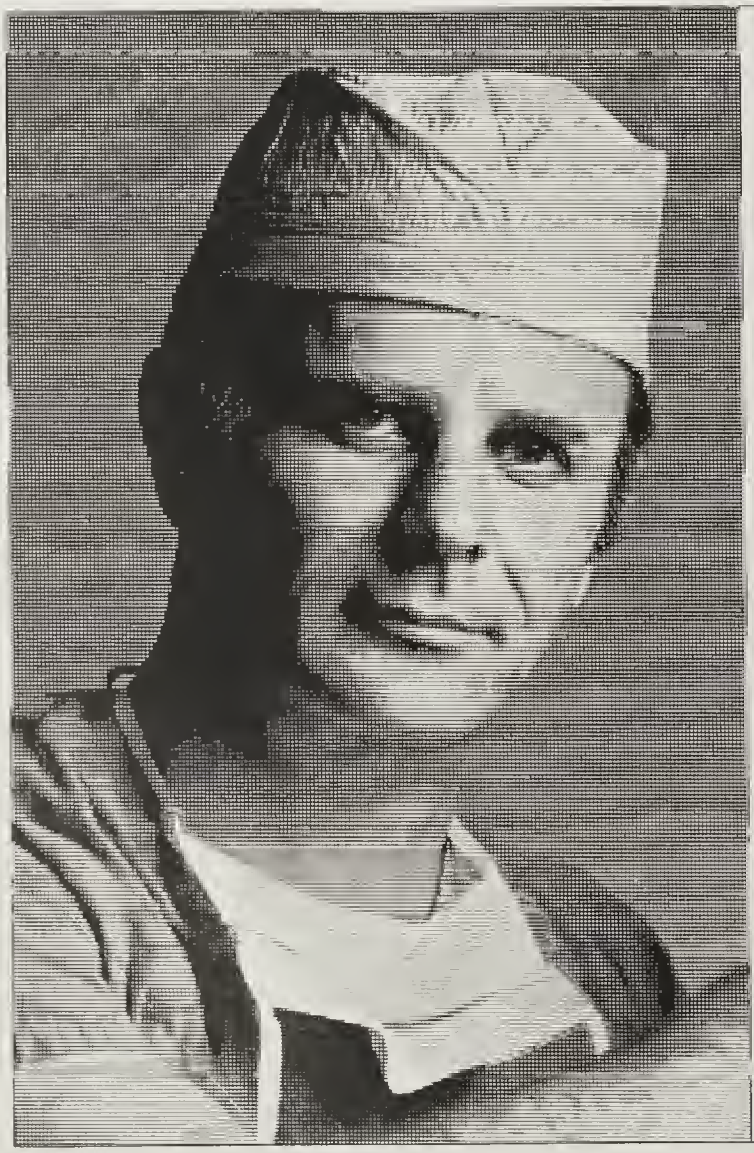
STRATEGIES/Continued

marketing tactics; and implementing and controlling the marketing effort.

- *Corporate identity program*—A corporate identity program is a management tool that controls the visual appearance of Association communication materials, from letterheads and promotion through products and services. Such a program will be undertaken in 1987 to increase the likelihood that the Association receives the recognition it deserves for serving the needs of the profession and the public with quality products and services.

Strengthen Association financial base by the continued expansion of non-dues revenue opportunities.

To continue to support the Association's priority activities, AMA revenues must also continue to grow. In 1986, non-dues revenue accounted for 57 percent of total Association revenues. By 1987, this percentage is projected to increase to 60 percent. Several major new initiatives are expected to contribute substantially to the future growth of Association revenues from sources other than dues. ☐



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A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.

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The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were controlled merely with the addition of a diuretic to INDERAL LA.

or the noncompliant patients in your practice, INDERAL LA may ell be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

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Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

Please see next page for brief summary of prescribing information

The one you know best keeps looking bette

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm

Propranolol is not significantly dialyzable

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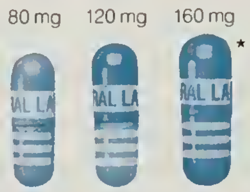
INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES



INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability ot heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-rec tor agonists and its effects can be reversed by administration of such agents, e g , dobulam or isoproterenol However, such patients may be subject to protracted severe hypotens Difficulty in starting and maintaining the heartbeat has also been reported with beta block

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appeara of certain premonitory signs and symptoms (pulse rate and pressure changes) of ac hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficu adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidi Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptc of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function te

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have b reported in which, after propranolol, the tachycardia was replaced by a severe bradyca requiring a demand pacemaker In one case, this resulted after an initial dose of 5 propranolol

PRECAUTIONS. *General* Propranolol should be used with caution in patients with impa hepatic or renal function INDERAL (propranolol HCl) is not indicated for the treatmen hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure Patients shc be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead return of increased intraocular pressure

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart dise elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as re pine should be closely observed if INDERAL is administered The added catecholam blocking action may produce an excessive reduction of resting sympathetic nervous act which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthost hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals h been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studie both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of sig cant drug-induced toxicity There were no drug-related tumorigenic effects at any of dosage levels Reproductive studies in animals did not show any impairment of fertility that attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in an studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women INDERAL shoulc used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers INDERAL is excreted in human milk Caution should be exercised w INDERAL is administered to a nursing woman

Pediatric Use Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have ra required the withdrawal of therapy

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypot sion, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of Raynaud type

Central Nervous System lightheadedne mental depression manifested by insom lassitude, weakness, fatigue, reversible me depression progressing to catatonia, vis disturbances, hallucinations, an acute reve ible syndrome characterized by disorienta for time and place, short-term memory lc emotional lability, slightly clouded sensor and decreased performance on neuropsyc metrics

Gastrointestinal: nausea, vomiting, epig tric distress, abdominal cramping, diarrh constipation, mesenteric arterial thrombo ischemic colitis.

Allergic pharyngitis and agranulocyto erythematous rash, fever combined with aching and sore throat, laryngospasm and respira distress

Respiratory bronchospasm

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purp

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been ported

Miscellaneous alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impote and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involv the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride sustained-release capsule for administration once daily If patients are switched from INDE tablets to INDERAL LA capsules, care should be taken to assure that the desired therape effect is maintained INDERAL LA should not be considered a simple mg for mg substitute INDERAL INDERAL LA has different kinetics and produces lower blood levels Retitration r be necessary especially to maintain effectiveness at the end of the 24-hour dosing interva

HYPERTENSION — *Dosage must be individualized* The usual initial dosage is 80 INDERAL LA once daily, whether used alone or added to a diuretic The dosage may increased to 120 mg once daily or higher until adequate blood-pressure control is achiev The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosage of mg may be required The time needed for full hypertensive response to a given dosag variable and may range from a few days to several weeks

ANGINA PECTORIS — *Dosage must be individualized* Starting with 80 mg INDERAL once daily, dosage should be gradually increased at three to seven day intervals until optim response is obtained Although individual patients may respond at any dosage level, average optimum dosage appears to be 160 mg once daily In angina pectoris, the value safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (WARNINGS)

MIGRAINE — *Dosage must be individualized* The initial oral dose is 80 mg INDERAL once daily The usual effective dose range is 160-240 mg once daily The dosage may increased gradually to achieve optimum migraine prophylaxis If a satisfactory response is obtained within four to six weeks after reaching the maximum dose, INDERAL LA ther should be discontinued It may be advisable to withdraw the drug gradually over a perio several weeks

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are limited to permit adequate directions for use

*The appearance of these capsules is a registered trademark of Ayerst Laboratories

---

REFERENCES:

1. INDERAL LA National Compliance Evaluation Program Data on file, Ayerst Laborator
2. Ravid M, Lang R, Jutrin I The relative antihypertensive potency of propranolol, oxprenc atenolol, and metoprolol given once daily *Arch Intern Med* 1985,145 1321-1323

6412/1

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Patients needed for studies

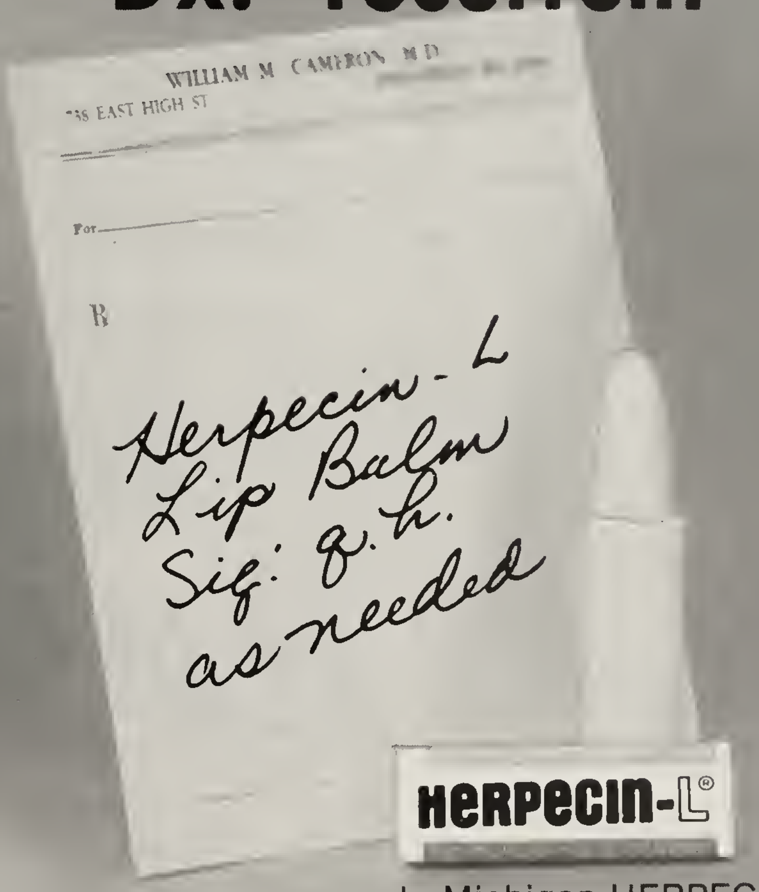
Monoclonal antibody lymphoscintigraphy in melanoma

This protocol uses radiolabeled monoclonal antibodies reactive with a surface antigen expressed on melanomas in an effort to detect foci of residual neoplasia in lymph nodes draining the site of a primary melanoma. The radiolabeled anti-melanoma antibody is injected about the site of the primary melanoma, and the lymph nodes draining the region are scanned using a gamma camera. This imaging study can be conducted on any patient over the age of 18 with a newly-diagnosed melanoma 1) with the lesion measuring in excess of 2.0 mm in thickness and 2) have lymph node dissection planned as part of therapy. This surgery (which would need to be performed at the University of Michigan so that autoradiography could be performed) will allow us to determine if sites of increased uptake on radioantibody scan in fact represent tumor. This work's goal is to develop a scan that will rationally allow us to select patients for lymph node dissection.

The patients selected for this study would be hospitalized for 3-6 days in the Clinical Research Center at the University of Michigan Medical Center. They would be injected with .5-2 mCi of I131 labeled murine monoclonal antibody. Images, blood and

Continued on page 192

Dx: recurrent herpes labialis



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In Michigan HERPECIN-L is available at all *Perry, Revco, RiteAid, Sentry, SupeRx Drug Stores* and other select pharmacies.

STUDIES/Continued

urine samples would be acquired over the time of the hospitalization.

Costs for the hospitalization and scanning are covered by NIH grants. Any surgery done would need to be covered by the patient's health care coverage plan.

Contact person for referral: Richard L. Wahl, MD, Department of Internal Medicine, Division of Nuclear Medicine, University of Michigan Medical Center, Ann Arbor 48109-0028 (313)936-5384.

Noradrenergic and neuroendocrine function in patients with depression

The Psychiatry Department of the University of Michigan is currently expanding its research programs in the area of electroconvulsive therapy (ECT) in patients with depression. Even though still considered one of the most effective treatment modalities for depression, there is much to learn about the mechanisms of action and long-term outcome with ECT. We currently are involved in the assessment of the noradrenergic and neuroendocrine function in depressed patients treated with ECT and the changes in these biological indices following the treatment with ECT.

We are interested in patients with either psychotic or treatment resistant depression in need of ECT treatments. Patients may need to be hospitalized in the Clinical Studies Unit or be treated as outpatients with brief inpatient stays at the Clinical Research Center for the research procedures. The research to be done involves some catheter studies preceding and following the course of ECT. The medication yohimbine will be administered as a challenge to both the noradrenergic and the neuroen-

Continued on page 194

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Mutual Memo

4

Fourth in a series

How clear hand-writing can reduce medical liability risk

TO: Michigan Physicians

FROM: Loss Prevention, Underwriting and Claims Departments

RE: Preventing claims through legible handwriting

One of the easiest ways to reduce your exposure to a professional liability claim is to write medical records clearly.

A recent study published by two physicians in the New England Journal of Medicine confirms that illegible medical records can be a source of professional liability risk.

The study revealed that illegible handwriting reduced reading comprehension of medical progress notes by physicians themselves in 42% of the records screened.

Illegible medical records can cause ancillary personnel to make medication mistakes and other errors that may lead to patient injury.

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docrine system. We have very good experience with this drug—its use is devoid of significant side effects and is very well tolerated by the patients. Future studies in this population will involve magnetic resonance imaging (MRI) of the brain and also positron emission tomography (PET). Patients will be offered long-term follow-up in our outpatient department, and we are most interested in working closely with the referring physicians following the discharge.

Contact person for referral: Leon J. Grunhaus, MD, Clinical Studies Unit, U-M Hospitals, D9702, Box 0118, 1500 E. Medical Center Drive, Ann Arbor 48109-0118.

Monoclonal antibody radioimmunodetection of choriocarcinoma

This protocol uses radiolabeled monoclonal antibodies reactive with a surface antigen expressed on malignant choriocarcinomas in an effort to detect foci of residual neoplasia. This imaging study can be conducted on any patient over the age of 18 with a history of choriocarcinoma and an elevated B-HCG. Ideally the patient selected will have had resection of the primary study and be a candidate for additional curative surgery which would allow us to determine if sites of increased uptake on radioantibody scan in fact represent tumor.

Other patients eligible would be those with measurable disease on whom the scan could serve as an additional staging measure.

The patients selected for this study would be hospitalized for 3-6 days in the Clinical Research Center at the University of Michigan Medical Center. They would be injected with .5-2 mCi of 1131 labeled murine monoclonal antibody. Images, blood and urine samples would be acquired over the time of the hospitalization.

Costs for the hospitalization and scanning are covered by NIH grants. Any surgery done would need to be covered by the patient's health care coverage plan.

Contact person for referral: Richard L. Wahl, MD, Department of Internal Medicine, Division of Nuclear Medicine, University of Michigan Medical Center, Ann Arbor Michigan 48109-0028 (313)936-5384.

The effects of cisapride in chronic severe idiopathic constipation

Cisapride is a new, potent, investigational prokinetic agent useful in a variety of gastrointestinal motility disorders. We are studying the effects of this drug in patients with chronic, difficult-to-manage, idiopathic constipation. Colonic transit and anorectal motility studies will be performed followed by 6-8 weeks of double-blind, placebo controlled treatment with cisapride. After this study period, diagnostic tests will be repeated at no cos to the patient and up to two years of open label cisapride will be provided free of charge.

Contact person for referrals: Jeffrey L. Barnett, MD, 3912 Taubman Center, 1500 E. Med. Campus Dr., University of Michigan Medical Center, GI Division, Ann Arbor, Michigan 48109-0362 (313)936-4785.

Malignant astrocytomas: intra-arterial BUdR radiosensitization and radiotherapy post-surgical decompression

Patients are entered into the study following tissue diagnosis of grade III-IV malignant astrocytoma. Upon entry, an intra-arterial carotid infusion pump is placed into the carotid artery ipsilateral to the tumor. Bromodeoxyuridine (BUdR) is infused continuously through this pump for eight weeks, two weeks prior to the initiation of radiation therapy and for the six weeks of radiation therapy. Radiation therapy is administered focally to the tumor and minimal surrounding area 5 days/week for approximately six weeks. Patients are followed with CT scans until treatment failure and then are given regional chemotherapy through the sideport of the infusion pump. This study is funded by NIH R01 CA33768. Costs for patient pumps are funded and hospitalization costs covered if there is no private in-

Continued on page 196

EMERGENCY MEDICINE - GROUP POSITION

Saginaw, Michigan

THE POSITION: For many years the Emergency Department at Saginaw General was managed and staffed through a contractual arrangement with a regional Emergency Department management group. In September 1986 the Emergency Department at Saginaw General was restructured under the guidance of Doctor David Pugh. The Department is now managed and staffed by hospital employed Emergency Medicine Physicians. This arrangement has been so successful that Doctor Pugh is looking to expand his current group from four to six members. Doctor Pugh is in his late thirties, Emergency Medicine trained, and an experienced and progressive director. This Level II Emergency Department treats up to 20,000 patients annually. The preferred candidates should be board eligible in Emergency Medicine with a family practice orientation. This orientation is important due to E.D.'s volume of pediatrics, and the fact that Saginaw General Hospital has the largest obstetrical service in the area. Preferred candidates are to possess an interest in assuming administrative duties and developing new programs, to be an enthusiastic team player with a willingness and commitment to build the best Level II Emergency Department in the tri-city area. Compensation parameters include a competitive salary based on experience and training, plus a comprehensive benefit relocation package.

THE HOSPITAL: Saginaw General Hospital is a 360 bed regional medical center, with all subspecialties represented on their active medical staff. All surgical procedures with the exception of open heart are performed. Saginaw General has the reputation of being the preferred specialty hospital within the tri-city region.

THE COMMUNITY: Saginaw is the largest of the tricities which includes Midland and Bay City. Saginaw has a county population of 225,000 and a documented commercial service area approaching one million residents. This multi-college community enjoys a diversified and stable economy. It is located 95 miles north of Detroit and 30 miles from the Shores of Lake Huron. Through carefully planned growth and expansion, Saginaw has become one of Michigan's most livable cities.

For additional information about this opportunity, please forward your curriculum vitae in confidence.

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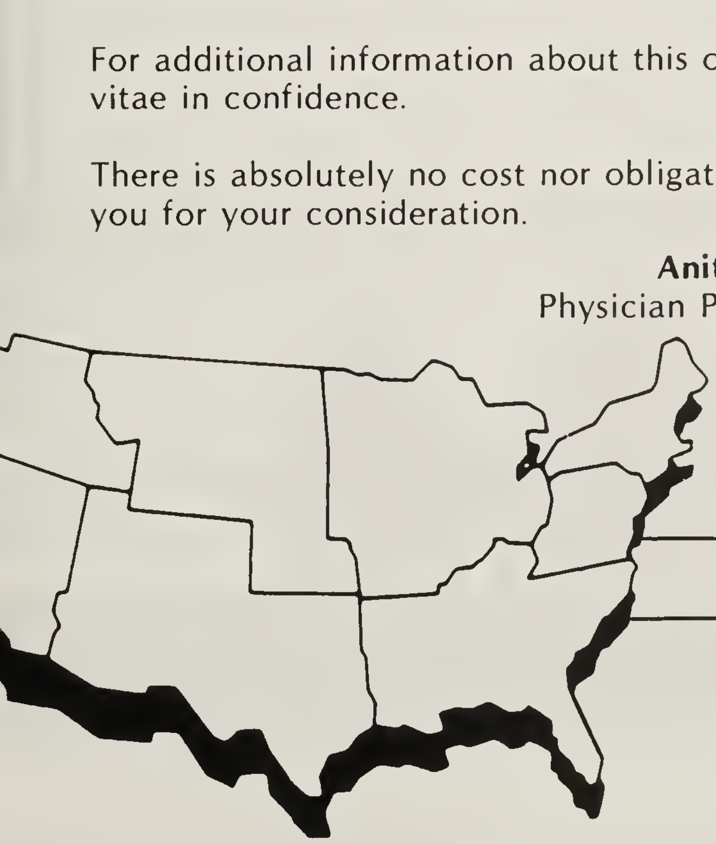
Anita R. Bowles
Physician Placement Specialist



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Contact persons for referral: Michaelyn A. Page, RN, MS, or Harry S. Greenberg, MD, 1914/0316 Taubman Center, Ann Arbor, Michigan 48109 (313)936-9055.

Serum glucose concentration as a modulator of gastric motility

Diabetes is characterized by numerous complications including gastroparesis. The pathophysiology of diabetic gastroparesis may be related to an autonomic neuropathy or myopathy. However, variations in symptoms of gastric dysmotility over days or weeks are well recognized. We have postulated that gastric emptying may be related to serum glucose levels. We have studied normal volunteers using a thin, wafer-perfused manometric tube under conditions of hyperglycemia and euglycomia. Our findings indicate that gastric motility is significantly inhibited during periods of hyper as opposed euglycemia. We suspect that hyperglycemia alone may play a pathogenic role in patients with diabetic gastroparesis.

PARTNERS National Health Plans, a partnership between VHA Enterprises, Inc. (the equity arm of Voluntary Hospitals of America) and the Aetna Life Insurance Company, is in the process of establishing a "Prudent Purchaser" provider network in the Detroit, Grand Rapids, Bay City and Saginaw areas. Michigan law (section 550.53, M.C.L.A.) requires PARTNERS to give certain health care providers in these geographical areas an opportunity to participate, subject to PARTNERS' right to limit the number of health care providers in the network.

Interested providers should contact, in writing,
Heidi Schelling
PARTNERS National
Health Plans
1300 Higgins Rd.
Suite 220
Park Ridge, IL 60068
by March 27, 1987, for further information.

We are actively seeking diabetic patients with gastroparesis to continue these motility studies.

Contact person for referrals: Jeffrey L. Barnett, MD, 3912 Taubman Center, 1500 E. Med. Campus Dr., University of Michigan Medical Center, GI Division, Ann Arbor, Michigan 48109-0362 (313)936-4785.

Monoclonal antibody radioimmunodetection of testicular carcinoma

This protocol uses radiolabeled monoclonal antibodies reactive with a surface antigen expressed on non-seminomatous testicular tumors in an effort to detect foci or residual neoplasia. This imaging study be conducted on any patient over the age of 18 with a germ cell tumor of the testis. Ideally the patient selected will have had resection of the primary study and be a candidate for additional curative surgery which would allow us to determine if sites of increased uptake on radioantibody scan in fact represent tumor.

Other patients eligible would be those with measurable disease on whom the scan could serve as an additional staging measure.

The patients selected for this study would be hospitalized for 3-6 days in the Clinical Research Center at the University of Michigan Medical Center. They would be injected with .5-2 mCi of 1131 labeled murine monoclonal antibody. Images, blood and urine samples would be acquired over the time of the hospitalization.

Costs for the hospitalization and scanning are covered by NIH grants. Any surgery done would need to be covered by the patient's health care coverage plan.

Contact persons for referral: Richard L. Wahl, MD, Department of Internal Medicine, Division of Nuclear Medicine, U-M Medical Center, Ann Arbor Michigan 48109-0028 (313)936-5384, or H. Barton Grossman, MD, Section of Urology, Department of Surgery, U-M Medical Center, Ann Arbor Michigan 48109-0330 (313)936-5755.

The role of endogenous opioids in hypothalamic amenorrhea

Women with hypothalamic

Continued on page 198

AIM HIGH

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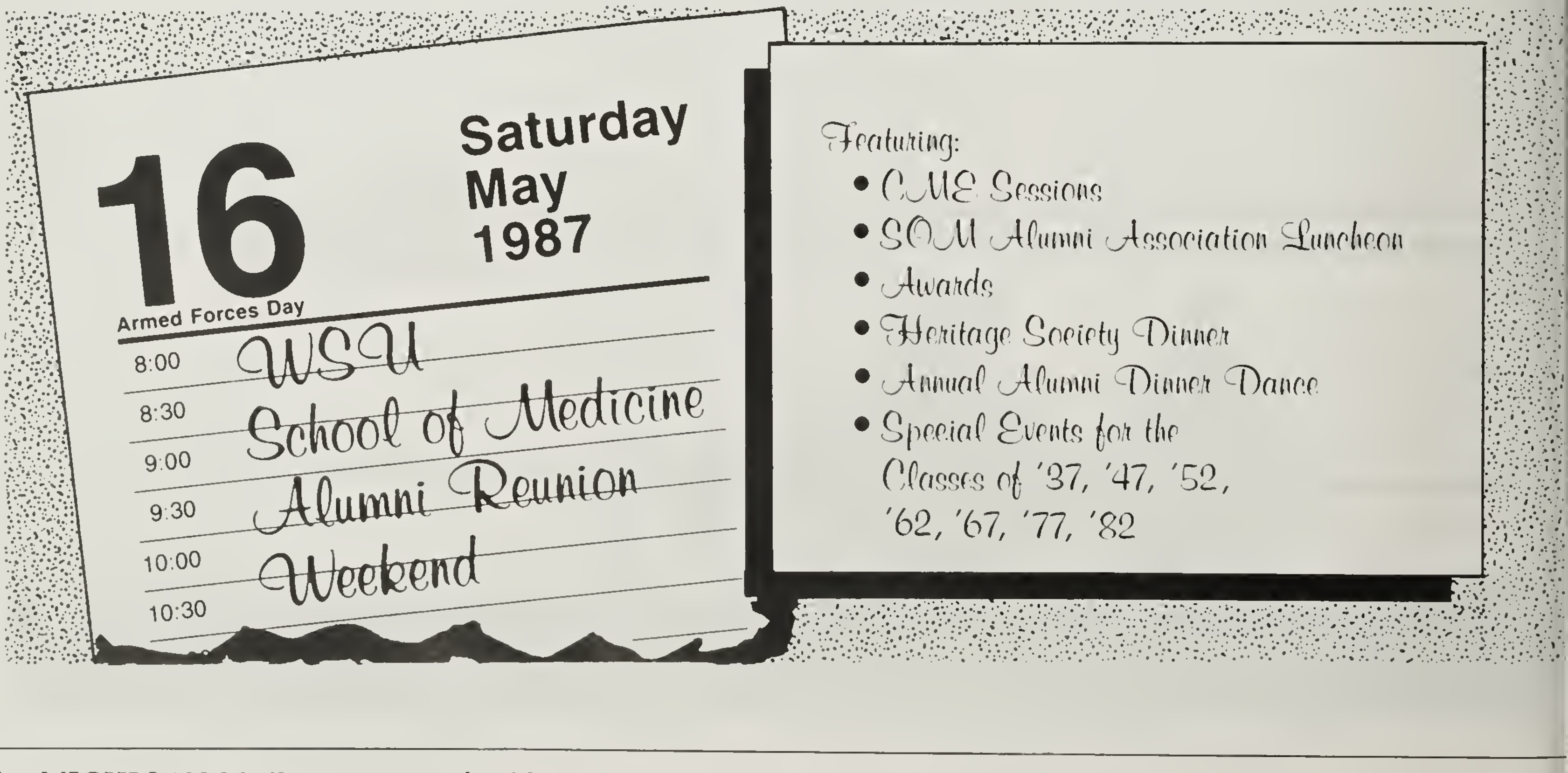
AIR FORCE

STUDIES/Continued

amenorrhea (HA) have been shown to have abnormal secretion of hypothalamic gonadotropin releasing hormone (GnRH) and in turn, abnormal secretion of the pituitary gonadotropins luteinizing hormone (LH) and follicle stimulating hormone (FSH). GnRH is secreted in a pulsatile fashion and GnRH pulse frequency in humans is determined by measuring peripheral LH pulse frequency. The frequency of GnRH pulses changes during the menstrual cycle and these changes are important in maintaining regular menstrual cycles. In normal women with regular menstrual cycles the follicular phase is characterized by LH pulses at a fast, regular frequency (approximately one pulse every 60-90 minutes) and of uniform amplitude. The luteal phase is characterized by LH pulses at a slow, irregular frequency (less than 50 percent of rate seen in follicular phase) and of nonuniform amplitude. Most women with hypothalamic amenorrhea secrete LH pulses at a slow frequency, similar to that seen in the normal luteal phase and are unable to increase the LH pulse frequency to the rate seen in the normal follicular phase. This results in absence of ovarian follicular maturation, anovulation and amenorrhea.

We have postulated that increased hypothalamic endorphin activity is responsible for the slow GnRH pulse frequency observed in women with HA. Initial studies examined the acute effect of opioid antagonism on LH (and by inference) GnRH pulse frequency in women with HA. In 60% of the women studied, LH pulse frequency increased to the rate seen in the normal follicular phase. Maintaining this faster LH pulse frequency in women with HA should induce ovarian follicular development and resumption of ovulatory menstrual cycles. If Naltrexone administration is successful in inducing ovulatory cycles this would represent an important therapeutic advance for women with HA who do not respond to conventional therapies such as clomiphene citrate.

Contact person for referrals: *John C. Marshall, M.D., Ph.D., 3110 Taubman Center — Box 0368, Ann Arbor 48109 (313) 936-4350.*



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Saturday May 1987

Armed Forces Day

8:00 WSU

8:30 School of Medicine

9:00 Alumni Reunion

9:30 Weekend

10:00

10:30

Featuring:

- CME Sessions
- SOM Alumni Association Luncheon
- Awards
- Heritage Society Dinner
- Annual Alumni Dinner Dance
- Special Events for the Classes of '37, '47, '52, '62, '67, '77, '82

MSMS MEETINGS

March

21, MSMS Hospital Medical Staff Section Annual Meeting, Hyatt Regency, Dearborn, contact: Thomas White, MSMS headquarters (517)337-1351.

April

11, Listening: Better Communications, Peer to Peer Workshop for Women Physicians, Southfield Hilton, contact: Linda Munson, MSMS headquarters (517)337-1351.

24-25, MSMS House of Delegates, Amway Grand Plaza, Grand Rapids, contact: Richard Campau, MSMS headquarters (517)337-1351.

May

21-22, Committee on Maternal and Perinatal Health, Gull Lake Conference, MSU Gull Lake Conference Center, contact: Katie Brewbaker, MSMS headquarters (517)337-1351.

June

14-19, School Worksite Wellness, MSMS, Michigan Health Council and others, Mackinac Island, contact: Debbie Zannoth, MSMS headquarters (517)337-1351.

17, Effective Writing, a workshop for county medical society editors, executive directors, medical writers and journalism students, Radisson Hotel, Lansing, contact: Judy Marr or Sherry Wellman, MSMS headquarters (517)337-1351.

July

16-19, MSMS Board of Directors Midsummer Meeting, Deer Lake, Boyne Mountain, contact: William Madigan (517)337-1351.

September

23, MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

October

14, County Medical Society Executives Meeting, MSMS headquarters, East Lansing, contact Wayne Burmeister, MSMS headquarters (517)337-1351.

21, 1987 Public Affairs Leadership Conference, Clarion Hotel and Conference Center, Lansing, contact: Sherry Wellman, MSMS headquarters (517)337-1351.

November

18, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

AMA MEETING
May

7-8, AMA National Conference on AIDS, Marriott Hotel, Chicago, contact: Pat Clark, AMA (312)645-4497.

MSMS/A, AMA/A
May

4-6, MSMS Auxiliary Annual Meeting, Holiday Inn, Petoskey, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

MICHIGAN SPECIALTY SOCIETY MEETINGS

April

3, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

11, Michigan Society of Anesthesiologists Annual Meeting, Novi Hilton, contact: Caroline Rich, MSMS headquarters (517-337-1351).

15, Michigan Allergy Society Meeting, Children's Hospital of Michigan, contact: Viola M. Heins, MSMS headquarters (517-337-1351).

30-5/1, Michigan Chapter, American College of Surgeons, Annual Coller Day Competition and Scientific Meeting, Amway Grand Plaza, Grand Rapids, contact: Viola M. Heins, MSMS headquarters (517) 337-1351.

May

1, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313) 243-7144.

15-17, Michigan Association of Medical Education Annual Meeting, Holiday Inn, Petoskey, contact:

Continued on next page

Viola M. Heins, MSMS headquarters (517)337-1351.

16-17, Michigan Society of Pathologists Annual Meeting, St. Clair Inn, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

19-22, Michigan Society of Respiratory Care, Flint Hyatt Regency, contact: Caroline Rich, MSMS headquarters (517)337-1351.

20, Michigan Allergy Society Meeting, University of Michigan, Ann Arbor, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

June

5, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

25-28, Michigan Otolaryngological Society, Summer Scientific Meeting, The Homestead, Glenn Arbor, contact: Karen Turner, executive secretary (313)567-1640.

July

10, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

10-11, Michigan Society of Thoracic Surgeons Annual Meeting, Grand Traverse Resort Village, Traverse City, contact: Rodman E. Taber, MD, secretary (313) 567-1640.

10-12, Michigan Dermatological Society, Grand Traverse Resort Village, Traverse City, contact: Debbie Samalis, executive secretary (313)554-1891.

August

15-16, Michigan Academy of Family Physicians Congress of Delegates, Grand Traverse Resort Village, Traverse City, contact: Janice Klos, chief executive officer (517)482-7410.

17-19, Michigan Academy of Family Physicians Annual Meeting, Grand Traverse Resort Village, Traverse City, contact: Janice Klos, chief executive officer (517) 482-7410.

18-21, Michigan Health Officers Association, Annual General Membership Meeting, Grand Traverse Resort Village, Traverse City, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

19-20, Michigan Society of Thoracic Surgeons Meeting, Grand Hotel, Mackinac Island, contact: Rodman E. Taber, MD, secretary (313) 567-1640.

September

4, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

October

2, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

November

6, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

CATEGORY I COURSES

ichigan Medicine each month carries a list of opportunities in Michigan for doctors of medi-ine to obtain Category 1 credit toward meeting the requirements of Michigan law. Sponsors f Category 1 programs and courses in Michigan are invited to submit information for the monthly alendar.

ach listing below, of programs that carry at least 3 hours of Category I credit, indicates a con-act person so the physician can obtain details. Physicians with questions about accredited pro-rams may phone MSMS headquarters, (517) 337-1351.

March

25-26, Michigan Conference on Maternal nd Perinatal Health. **Location:** Hyatt Re-ency, Dearborn. **Sponsor:** MSMS. **Contact:** herry Fent, 120 W. Saginaw, East Lansing 8826-0950 (517)337-1351. **Approved for:** 14 ours of Category 1 Credit.

28, Emergency Medicine Oral Boards Prep-ration Workshop. **Location:** St. Mary's Hos-pital, Saginaw. **Sponsor:** St. Mary's Hospital nd Michigan State University College of Os-eopathic Medicine. **Contact:** Michigan ACEP, 1305 Abbott Road, Suite 104, East ansing 48823. **Approved for:** 5 hours of ategory I Credit.

April

1, Pulmonary Rehabilitation Symposium. ocation: Fetzer Center, Western Michigan niversity, Kalamazoo. **Sponsor:** Pulmonary ervices, Borgess Medical Center and South-vestern Michigan Area Health Education enter. **Contact:** Judy Smith, Pulmonary Ser-ices, Borgess Medical Center, 1521 Gull oad, Kalamazoo 49001 (616)383-4875. **Ap-roved for:** 5 hours of Category 1 Credit.

3-5, Tutorial on Level I Myofascial Release echnique. **Location:** Kellogg Center for ontinuing Education, MSU. **Sponsor:** MSU ollege of Osteopathic Medicine and College f Human Medicine. **Contact:** Sandy ilbourn, MA, Director of Continuing Med-cal Education, MSU College of Osteopathic edicine, A306 E. Fee Hall, East Lansing 8824 (517)353-9714. **Approved for:** 24 hours f Category 1 Credit.

6-8, Eleventh Annual Advances in Emergency Care: Tricks and Tools of the Trade, New and Old. **Location:** The Towsley Center for Continuing Medical Education, The University of Michigan Medical School. **Sponsor:** The University of Michigan Medical School and Michigan Chapter, American College of Emergency Physicians. **Contact:** Betty Phillips, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-1400 (313) 763-1400. **Approved for:** 18.5 hours of Category 1 Credit.

6-9, Advanced Cardiac Life Support Provider Course. (April 6 and 8 Recertification Course—8 Category I Credits—4 for BCLS and 4 for ACLS). **Location:** Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Center—Staff and Patient Education Department. **Contact:** Claire A. Zieman, Staff and Patient Education, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-8320. **Approved for:** 25 Credits, 4 for BCLS and 21 for ACLS.

6-10, Tenth Annual Spring Workshop, Head and Neck Oncology Course. **Location:** Towsley Center for Continuing Medical Education, University of Michigan. **Sponsor:** University of Michigan Medical School. **Contact:** Jolene Glaspie (313)763-1400. **Approved for:** 43.5 hours of Category 1 Credit.

10, Flexible Sigmoidoscopy Conference. **Location:** Gilmore Health Education Center, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Charles L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 5.5 hours of Category 1 Credit.

May

1, 11th Annual Preventive Cardiovascular Medicine and Rehabilitation Symposium. **Location:** John E. Fetzer Business Development Center—Kirsch Auditorium, Western Michigan University, Kalamazoo. **Sponsor:** Borgess Medical Center—Institute for Cardiovascular Health, Southwestern Michigan Area Health Education Center, American College of Sports Medicine and American Heart Association. **Contact:** Jeff Morgan, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 5 hours of Category 1 Credit.

7-9, Medicolegal Investigation of Death. **Location:** Hotel Pontchartrain, Detroit. **Sponsor:** Wayne State University School of Medicine Department of Pathology, Wayne County Medical Examiner's Office, with the cooperation of the Criminal Defense Attorneys of Michigan. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4-H University Health Center, 4201 St. Antoine, Detroit 48201 (313)577-1180. **Approved for:** 15.5 hours of Category I Credit.

9, Microsurgical Solutions to Reconstructive Problems in the Extremities. **Location:** The Westin Hotel O'Hare, Chicago. **Sponsor:** The American Society For Surgery of the Hand in cooperation with the American Society for Reconstructive Microsurgery. **Contact:** American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, Colorado 80014 (303)7554588.**Approved for:** 8 hours of Category I Credit.

11-15, 15th Annual Spring Update, Advances in Internal Medicine. **Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Internal Medicine, Ann Arbor. **Contact:** Georgia Barton, Office of Continuing Medical Education, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 33.5 hours of Category I Credit.

Continued on next page

MAY CME/Continued

14, Sports Medicine/MATS Conference. **Location** Marriott Inn, Ann Arbor. **Sponsor:** Michigan State Medical Society and Michigan Athletic Trainers Society, in cooperation with Michigan High School Athletic Association. **Contact:** Sherry L. Fent, MSMS, 120 W. Saginaw, East Lansing 48826-0950 (517) 337-1351. **Approved for:** 6 hours of Category I Credit.

14, Sexually Transmitted Diseases—1987. **Location:** Fetzer Business Development Center, Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Charles L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 6 hours of Category I Credit.

14, Perinatal Periscope—A Look to the Future. **Location:** Bernhard Student Center, Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association, Southwestern Michigan Area Health Education Center and the American Academy of Family Physicians. **Contact:** Wendy Finsterwald, Southwestern Michigan Perinatal Association, 252 East Lovell Street, Kalamazoo 49007 (616)383-4669. **Approved for:** 6 hours of Category I Credit.

15-17, Advanced Cardiac Life Support (Provider & Recertification) Course. **Location:** Gilmore Center of Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Life Support Services and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. **Approved for:** Category I Credit: 20 credits for ACLS and 6 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

15-17, The Differential Diagnoisis of Musculoskeletal Pain: Emphasis on the Low Back. **Location:** Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU College of Osteopathic Medicine, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 20 hours of Category I Credit.

16-17, A Practical Approach for Differential Diagnosis of Diseases of Lymph Nodes, Genito-Urinary Pathology — New Developments in Diagnostic Techniques, Risk Management. **Location:** St. Clair Inn. **Sponsor:** Michigan Society of Pathologists. **Contact:** Viola M. Heins, MSMS, 120 W. Saginaw, East Lansing, 48826-0950 (517)337-1351. **Approved for:** 7 hours of Category I Credit.

20, Current Update in the Treatment of Breast Carcinoma. **Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital Continuing Medical Education Committee. **Contact:** Carol Mastroianni, Program Coordinator, CME, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313)343-3877. **Approved for:** 8 hours of Category I Credit.

27-31, Tutorial on Level II Manual Medicine Techniques (Below Diaphragm). **Location:** Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU College of Osteopathic Medicine, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

June

4-5, 13th Annual Kalamazoo Symposium for Michigan Neonatologists and Neonatal Fellows. **Location:** Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Neonatology Services of the Pediatric Section, Bronson Methodist Hospital and Mead Johnson Laboratories. **Contact:** John V. Hartline, MD, Neonatology Services of the Pediatric Section, Bronson Methodist Hospital, 252 East Lovell, Kalamazoo 49007. **Approved for:** 7.25 hours of Category I Credit.

August

31-9/3, Advanced Cardiac Life Support Provider Course. (August 31 and September 2 Recertification Course—8 Category I Credits—4 for BCLS and 4 for ACLS). **Location:** Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Center, Staff and Patient Education Department. **Contact:** Claire A. Zieman, Staff and Patient Education, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616) 383-8320. **Approved for:** 25 Credits (4 for BCLS and 21 for ACLS).

September

10-12, Advanced Cardiac Life Support (Provider & Recertification) Course. **Location:** Gilmore Center of Health Education Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Life Support Services and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. **Approved for:** Category I Credit: 20 credits for ACLS and 4 credits for BCLS; Recertification-4 credits for ACLS and 5 for BCLS.

19, Emergency Medicine Oral Boards Preparation Workshop. **Location:** St. Mary's Hospital, Saginaw. **Sponsor:** St. Mary's Hospital and Michigan State University College of Osteopathic Medicine. **Contact:** Michigan ACEP, 1305 Abbott Road, Suite 104, East Lansing 48823. **Approved for:** 5 hours of Category 1 Credit.

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 40¢ per word, with a minimum charge of $20.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

PEDIATRICS—SOUTHEASTERN WISCONSIN. Large multi-specialty group located near Milwaukee is seeking a fourth BE/BC pediatrician. Competitive salary; excellent fringe benefits. Address inquiries and CV to Administrator, PO Box 427, Menomonee Falls, Wisconsin 53051.

ANESTHESIOLOGIST—BOARD ELIGIBLE/CERTIFIED anesthesiologist with particular interest in obstetrical anesthesia to join MDA/CRNA practice in Lansing, Michigan. Sparrow Hospital is a 502-bed, Level III, perinatal facility with 4,300 births and 12,500 surgical cases per year. In-house call is required. Send CV or contact K. S. Rudman, MD, Sparrow Hospital, 1215 E. Michigan Avenue, Lansing 48909 or call (517)483-2700.

ANESTHESIOLOGIST WANTED to join Central Wisconsin Anesthesiology, S.C. which consists of four established, hospital based anesthesiologists. All specialties are served including open heart, neuro, obstetrics and gynecology. If interested, phone (715)845-5505 or write to: Central Wisconsin Anesthesiology, SC, 425 Pine Ridge Blvd., Suite 207, Wausau, WI 54401.

MICHIGAN, ANN ARBOR-DETROIT AREA: Looking for career oriented emergency physicians board certified/prepared in emergency medicine, internal medicine, surgery or family practice. Directorships with stipends available. Excellent compensation including malpractice insurance. Contact: Emergency Consultants, Inc., One Windemere Place, Petoskey 49770; 1-800-253-7092 or in Michigan 1-800-632-9650.

MICHIGAN: EMERGENCY CONSULTANTS, INC. currently staffs Emergency Departments through out the state. Full time and part time positions available in rural and urban locations. Guaranteed hourly rate plus malpractice insurance. contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 23, Traverse City 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

UPPER PENINSULA, WESTERN—Seeking full time emergency department physician for low volume facility. Attractive weekday schedule. Contact Emergency Consultants, Inc., One Windemere Place, Room 23, Petoskey 49770; 1-800-253-7092 or in Michigan 1-800-632-9650.

BOARD CERTIFIED RADIOLOGIST. Permanent part time position open in new community hospital in scenic upper peninsula. Excellent salary, malpractice insurance. Ideal for semi-retired physician. Must do general radiology, nuclear medicine, ultrasound, CT and some invasive procedures. Write to: Mario Nunez, MD, 750 Lake Shore Drive, Escanaba 49829.

EMERGENCY PHYSICIANS NEEDED Chicago, Illinois. Full or part time. Prefer Board Certified or Eligible in Emergency Medicine, or at least three years full time experience. New contractual situation with new group will offer outstanding growth possibilities and excellent compensation. Take advantage of this exciting opportunity to work and live in dynamic Chicago. Send resume as soon as possible to: MEDICAL DIRECTOR, 666 North Lake Shore Drive, Lake Residence, Suite 1506, Chicago, Illinois 60611, or call (312)944-6969. Please don't delay in responding to this wonderful opportunity as there are only four positions available.

EMERGENCY ROOM OPENINGS: Experienced emergency medicine physician/family practitioner/internist/general surgeon. 96 + bed hospital staffing ER/Industrial Clinic with combined annual visits of 32K. Low trauma and low stress, flexible scheduling, coverage, hourly rate, and malpractice. Contact: Robin, Tyler and Company, Atlanta, GA 30338. Collect (404)641-6411.

GENERAL SURGERY PRACTICE FOR SALE, Farmington Hills Location. All furniture and fixtures, computer and medical equipment. Loyal referral base. Lease assignable/renegotiable. Staff is willing to stay at this desirable location. Call or write: MICHIGAN PRACTICE BROKERAGE CORPORATION, 20300 Civic Center Drive, Suite 230, Southfield 48076-4105 or (313)357-1663.

FAMILY PRACTITIONER OR INTERNIST willing to do Family Practice needed. If interested contact: Caro Family Physicians, 206 Montague, Caro 48723. Phone (517)673-2105.

FAMILY PRACTITIONER. Marshfield Clinic-Colby Center is seeking a Board certified/Board eligible Family Practitioner to join another Family Practitioner in an established office based group practice in Colby, Wisconsin. The Colby Center offers the Family Practitioner the autonomy of private, primary care practice, plus financial and professional resources of Marshfield Clinic, a 250 physician multispecialty group. This physician would enjoy full hospital privileges but without the distractions of OB or surgical responsibilities. Excellent salary and benefits. Please send curriculum vitae to Robert Peterson, Director, Regional Services, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449 or call collect at (715)387-5498.

EXCELLENT OPPORTUNITIES FOR—Otorhinolaryngologist, Obstetrician/Gynecologist, Psychiatrist, Endocrinologist, Radiologist, Orthopedist, Dermatologist and General/Family Practitioner. Excellent opportunity for physicians in Los Angeles suburb to join 80 member multispecialty medical group. Large fee-for-service and prepaid practice, no Medi-Cal. Excellent compensation program based on guarantee plus incentive, profit sharing and pension plan. Group provides health, dental, life and malpractice. Partnership in real estate and medical corporation available. See our Display Ad in this publication. Send CV to Wm. Shaw, Associate Administrator, Mullikin Medical Center, 17821 S. Pioneer Blvd., Artesia, CA 90701.

BE A "WINTER TEXAN" INTERNIST. Enjoy the warm, beautiful Rio Grande Valley while practicing internal medicine with an internist. Texas license essential. Salary, living accommodations and malpractice insurance. Send curriculum vitae: 104 South Bryan Road, Mission, Texas 78572 or contact (512)585-2783 for more information.

OB/GYN Catherine McAuley Health Center, a progressive multi-hospital health care corporation with a strong obstetrical service and teaching program, seeks to establish a new OB/GYN group practice. Guaranteed income through a subsidized practice arrangement or competitive salary/fringe benefits package. Must be board eligible or board certified. Starting date is negotiable—prefer 7/1/87 or earlier. For further information contact: F. W. Jeffries, MD, Department Chairman, Obstetrics/Gynecology, Catherine McAuley Health Center, 5301 East Huron River Drive, PO Box 992, Ann Arbor 48106.

SOLO INTERNIST SEEKS GENERAL INTERNIST to share in rapidly growing, fee-for-service practice. Subspecialty interest welcome. Well equipped office. 100-bed modern hospital excellent working and living environment. Call or write Robert Shannon, MD, 218 South James Street, Ludington 49431 (616)843-2525.

FULL TIME, PART TIME AND LOCUM TENENS GPs, PPs and Emergency Physicians needed to staff a network of convenience medical care centers located in Bay City, Saginaw, Midland and Mt. Pleasant, Michigan. Flexible hours and attractive compensation packages. Send CV to, or contact Contemporary Medical Management, 503 N. Euclid, Suite 4, Bay City 48796 (517)667-0672.

PEDIATRICS-IMMEDIATE OPENING available for general or subspecialty oriented pediatrician in large hospital based general pediatric group. Attractive southwest Michigan, university community with ample cultural and recreational opportunities. Send CV to Box 99, Michigan Medicine, 120 W. Saginaw, PO Box 950, East Lansing 48823.

GENERAL SURGEON/COLO-RECTAL MD or DO for busy, outpatient proctology/general surgery practice. Excellent opportunity for future independence and freedom. Franchise concept. Must explore. Send resume to: Hemorrhoid Clinics of America, 22000 Greenfield Road, Oak Park 48237, or call (313)967-4140.

FAMILY PRACTITIONERS, GENERAL PRACTITIONERS or Emergency Medicine Physicians with practice experience wanted for free-standing urgent care centers located in the Central Michigan area. Excellent access to recreational areas. Associ-

Continued on next page

CLASSIFIED/Continued

ate and Medical Director opening immediately. Salary negotiable plus fringe benefits. Send CV to Contemporary Medical Management, Incorporated, 401 South Euclid Avenue, Bay City 48706 (517)6670494.

EMERGENCY ROOM PHYSICIANS—full or part time positions. Rural Southwest Michigan. Competitive reimbursement; ACLS required; ATLS preferred. Nice rural community. Please send CV to President, SMES, 4341 S. Westnedge, Suite 1112, Kalamazoo 49008.

FAMILY PRACTITIONER AND INTERNAL MEDICINE SPECIALISTS to join seven doctor Family Practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well equipped 77 bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

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50% OFF PREVIOUSLY OWNED MEDICAL, laboratory, x-ray, ultrasound equipment. We buy, sell, broker, repair. Appraisals by certified surgical consultant. MEDICAL EQUIPMENT RESALE & REPAIR, INC., 24026 Haggerty Road, Farmington Hills 48018 (313)477-6880.

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"The green one was your pill. You took the red one. . . my blouse button."

MEDICAL PRACTICE SALES AND APPRAISALS. We specialize in the valuation and selling of medical practices. If interested in buying or selling a medical practice contact our Brokerage Division at The Health Care Group, 400 GSB Building, Bala Cynwyd, PA 19004 (215)667-8630.

DISCOVER A PHYSICIAN PLACEMENT SERVICE that puts your needs first! Current openings include FP, ER, Surgical, OB/GYN, PEDS, IM and others. Specialists in the desirable sunbelt. No fees, interview or relocation costs! Send CV to: Department M, Hunter, Holland and Ward, Inc., PO Box 17268, Raleigh, NC 27609 (919)876-5005.

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ACTIVE INTERNAL MEDICINE PRACTICE available for sale in Bay City. Call Commonwealth Health Care Group, Inc. (313)288-0022.

WE HAVE QUALIFIED PURCHASERS looking to purchase or leaseback Nursing Homes in Michigan. All inquiries are confidential. Call Commonwealth Health Care Group, Inc. (313)288-0022.

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WELL ESTABLISHED FAMILY PRACTICE of 43 years in fully equipped office for sale. Prime location across from McLaren Hospital at 420 South Ballenger, Flint. Please write or call (313) 234-0517 at the office of John E. Wentworth, MD.

GREAT LAKES ASSOCIATION OF CLINICAL MEDICINE PRESENTS: True Preventive Medicine. "Nutrition is Therapy": Jonathan Wright, MD of Wright/Gaby Foundation March 26-27 (1½ days). "Elemental Medicine": International Congress with noted speakers, March 27-28 (1½ days). Contact Warren Delano, 24700 Center Ridge Road, Westlake, Ohio 44145 (216)835-1212.

OAK PARK—Established General Practice for Sale. Great location—busy intersection—pleasant surroundings—well equipped—3 exam rooms—lab—x-ray room—large office. Great parking. Excellent starter or merge opportunity. Doctor leaving state. Call Professional Practice Sales, Inc., Herb Silverman, Associate Broker, 27208 Southfield Road, Lathrup Village 48076 (313)569-7336. All inquiries confidential.

SURGERY PRACTICE FOR SALE: Great Westland location. Established 15 years with excellent patient load. Hospital nearby. Beautiful brick building with three rental suites! Land Contract—"O" down. Excellent opportunity. Call Professional Practice Sales, Inc., 27208 Southfield Road, Lathrup Village 48076 (313)569-7336. Inquiries confidential.

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T. PLEASANT—FAMILY PRACTICE FOR ALE: In modern professional plaza in thriving col- ege town. Excellent patient location. . .Netting 14,000 monthly. Great opportunity—Call Now. rofessional Practice Sales, Inc., Herbert Silverman, ssociate Broker, 27208 Southfield Road, Lathrup illage 48076 (313)569-7336. Inquiries confidential.

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OCTOR IS RETIRING—Internal Medicine Prac- ice For Sale: Established 35 years in Westland with olid patient base. Beautiful brick building in ex- remely good condition. Three exam rooms. Hospi- al nearby. Grossing $145,000 on short work week. all Professional Practice Sales, Inc., 27208 South- ield Road, Lathrup Village 48076 (313)569-7336, erbert Silverman, Associate Broker. All inquiries onfidential.

UYING. . .SELLING. . .VALUING. . . Our only usiness. Call the experts first. Professional Practice ales, Inc., Herbert Silverman, Associate Broker, 7208 Southfield Road, Lathrup Village 48076 313)569-7336.

OR SALE: INTERNAL MEDICINE PRACTICE ocated in prosperous community within easy travel f Flint, Detroit, Ann Arbor, Lansing. Patient mixture comprised of 75 percent female. Sale of practice to include all office equipment. Write: ICDA, PO Box 6366, Saginaw 48608 or call Linkage Enterprises (517)799-0125 and ask for Mr. Ferris Finerty.

SOLO GYNECOLOGY PRACTICE FOR SALE. This solo gynecology practice has done no obstetrics for ten years. In the past six years (1981 through 1986) actual business was 2.72 million dollars and actual money collected was 2.49 million dollars. Mid Michigan community with excellent hospital (one), schools, parks, churches, colleges and golf courses. Ann Arbor and East Lansing are nearby. An experienced and superbly qualified team (certified registered nurse practitioner, registered nurse, master word processor and a receptionist) is willing to stay on. Owner will transmit clinical skills and introduce buyer to patients. Please reply to Box 101, Michigan Medicine, PO Box 950, East Lansing 49926-0950.

WISCONSIN RIVERVIEW HOSPITAL ASSOCIATION Symposium: The Transformation of the American Health Care System. Cosponsored by the State Medical Society of Wisconsin and the Wisconsin Hospital Association. Friday-Saturday, May 1-2, 1987, Mead Inn, Wisconsin Rapids, Wis. Nationally renowned speakers: Dr. Paul Starr, Prof of Sociology, Princeton Univ. Pulitzer Prize winner for "The Social Transformation of American Medicine;" Conan Edwards, AARP Lobbyist; Joseph Califano, Esq. Board Member, Chrysler Corporation; Edward R. Annis, MD, Past President, AMA; Wisconsin Governor Tommy Thompson; Wisconsin Congressman David Obey; Eugene Arnett, Chairman-elect, American Hospital Association and President, Memorial Hospital of Taylor County, Medford, Wisconsin; Tom Hefty, President, Blue Cross/Blue Shield United of Wisconsin, Milwaukee; and Robyn Shapiro, Esq, Director, Center for the Study of Bioethics, Medical College of Wisconsin, Milwaukee. Interested participants: representatives of Medicine, Hospital Administration, Law, State Government, Federal Government, Industry, Insurance and Consumer groups. Further information from Cochairman: Daniel J. Hymans, Admin., Riverview Hospital Association, 410 Dewey Street, Wisconsin Rapids, Wis. 54494 (715)423-6060, ext. 410; or John E. Thompson, MD, Chairman, Medical Staff Subcommittee, 75th Anniversary Task Force, Nekoosa Medical Center, 315 First St., Nekoosa, Wis. 54457 (715)886-3175.

EXCUSES/Continued

shelters, my country club sent out a big assessment for a new club house, my son turned sixteen so I bought him a new car, and my specialty society met in Las Vegas and, wow, did I have bad luck. Besides, I've got tennis lessons for my kids and, you know, with the entertaining my wife and I do, we have to have a lot of new clothes. Frankly, I can't afford to pay the dues and still put the maximum into my Keogh account."

(Finally an honest man.)

"What can I say except you wouldn't have the opportunity for all of that if it weren't for the AMA."

(Bottom line: "I don't want to (or can't) pay the $375.")

During my years of involvement I have heard all of the above excuses and more. They are just that—lame excuses to save $375. This comes out to a little over $1 a day—a small price to pay for the one organization trying to keep all of us free of further governmental encroachment into our practices. Those of you who are "freeloading" off the rest of us should rethink your excuses and join the AMA. Paying AMA dues is the price of professional freedom. ☐

Excuses, excuses, excuses

By Thomas R. Berglund, MD

"John, how about joining the AMA?"

"I would but I don't agree with their policies."

"Have you looked through the AMA policy manual? I am sure if you do you will find you agree with most of them! Gosh, I don't even agree with my wife 100 percent of the time! And the only way to change those policies is to work from within the organization."

"Well, I . . ." he sputters and walks off. (Bottom line: "I really don't want to pay the $375 dues.")

"Jean, how about joining the AMA?"

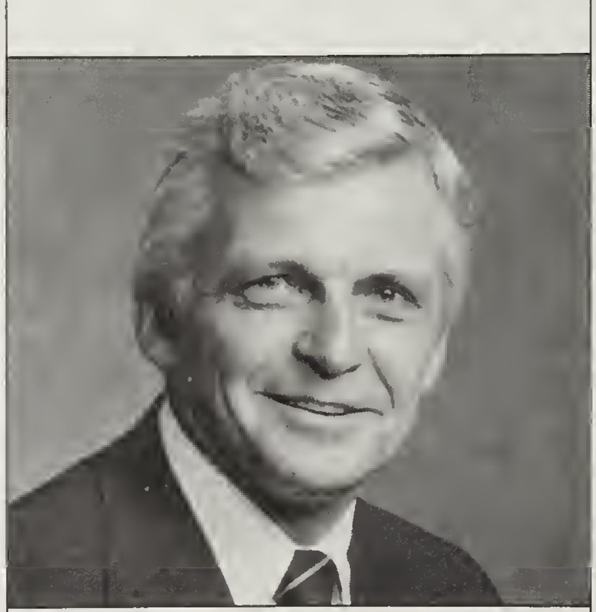
"I would, but it doesn't represent me."

"The AMA is probably the most representative organization in the world. Each county society in Michigan sends one representative to the MSMS House of Delegates for every fifty members. In turn, MSMS has one delegate to the AMA for every 1,000 members. The AMA really is a grass roots organization. I am a delegate to the AMA, so you see, you can get direct representation."

"Well, I . . ." she mutters and walks off. (Bottom line: "I really don't want to pay the $375 dues.")

"Jose, how about joining the AMA?"

"I would, but the AMA is made up of old retired doctors."



Thomas R. Berglund, MD

"I know my hair is gray, but I'm not retired and I'm a delegate to the AMA House of Delegates. One member of our delegation just turned forty. We have either a student or a resident on the delegation in a slotted spot. The AMA Board of Trustees includes both a student and a resident as members, and Alan Nelson, MD, chairman of the board, is in his early fifties—hardly ancient. What's more, at each House of Delegates meeting there is a Medical Students Section, a Resident Physicians Section and a newly created Young Physicians Section."

"Well, I . . ." he mumbles and walks away. (Bottom line: "I don't want to pay the $375 dues.")

"Mike, how about joining the AMA?"

"I belong to my specialty society."

"I do also and that's important, but it's the AMA that is leading the battle in Washington to lobby against mandated assignment under Medicare, Baby Doe regulations, fee freezes and the list goes on. We need a strong unified profession to have the most impact on national legislation."

"Well, I . . ." he stammers and walks off. (Bottom line: "I don't want to pay the $375 dues.")

"Joe, how about joining the AMA?"

"I would but they haven't done anything for me. Look, the new tax bill took away my shelters and many of my deductions. Every day we have more paper work and regulations. Why doesn't the AMA stop all this nonsense?"

"No organization can ever hope to be 100 percent successful in the give and take of the political arena. The AMA, however, has been more successful than most Western industrialized nations as is evidenced by the fact that the US is one of the very few countries where the health care system is not totally controlled by government. At this time when federal legislative and regulatory pressures are constantly increasing, can we afford not to have the strongest possible national association?"

"Well, I . . ." he stutters and walks off. (Bottom line: "I don't want to pay the $375 dues.")

"Charlie, how about joining the AMA?"

"I know I should but I just got hit by the IRS for penalties when they disallowed one of my tax

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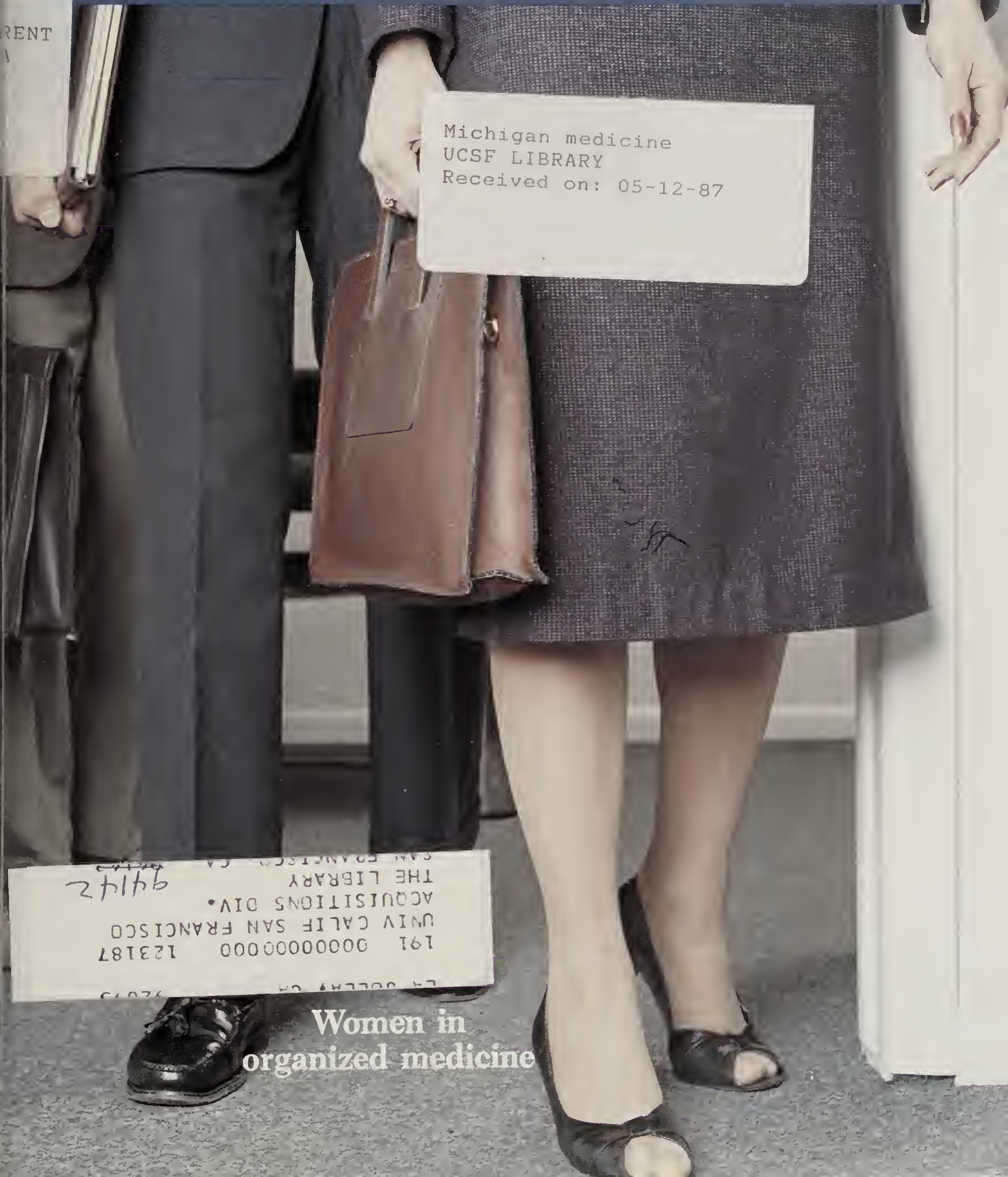
MICHIGAN MEDICINE

APRIL 1987 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY VOL. 86, NO. 4



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Women in organized medicine

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MICHIGAN MEDICINE

APRIL 1987 VOL. 86 NO. 4

Special Report

Women in medicine — should they have separate programs or should they take part in the mainstream of organized medicine? *Michigan Medicine* posed that question to half a dozen women physicians, and their answers, published here, vary. The MSMS Committee on the Concerns of Women Physicians was established to respond to those answers, and to continue to ask questions. Chairperson Vivian Lewis, MD, explains why she hopes that in the long run, the need for the committee will cease to exist. An AMA report details the socioeconomic characteristics of women MDs. Our Special Report ends with a discussion of listening skills, which was presented at a recent workshop sponsored by the committee. 211

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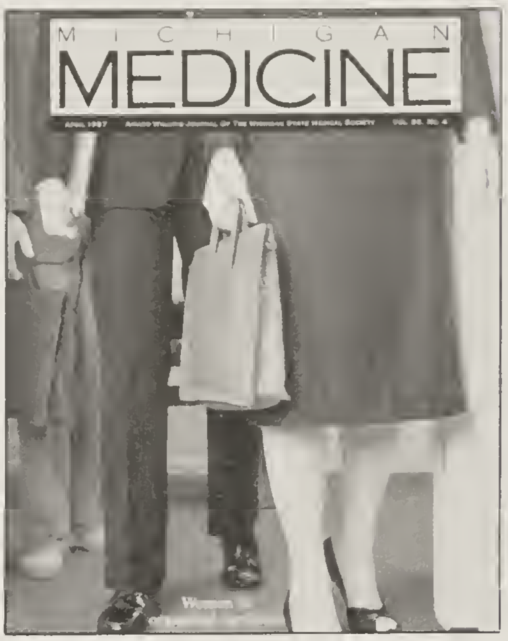

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In next month's issue of *Michigan Medicine:* Much of the practice of medicine is business. What do MDs need to know as employers?

Cover photo by Kim Kauffman.

Are you helping to fix it?

By Kenneth E. Rowe, MD

The author, Doctor Rowe, Hancock public health officer, is a member, MSMS Board of Directors and Committee on Publications.

The expression, "If it's not broken, don't fix it" is known to us all and is used to describe many situations in which a smoothly functioning organization, athletic team or other group continues to function in basically the same successful manner. To say that the health care delivery system does not need some fixing is indicative that we as physicians are either practicing in some very unusual circumstances, or that we are choosing to ignore much of the activity around us in our ever-changing professional lives.

The leadership of MSMS, particularly its officers, directors, task force chairpersons and committee chairpersons are working hard to bring about changes in an orderly manner which will allow the practicing physician to assure high quality health care for his/her patients. Whether the issue be malpractice insurance problems, managed health care delivery systems, regulations by third party payers, or dealing with the local, state and federal governments, there are multiple issues which have come to the attention of the various committees and task forces of MSMS.

As I read letters to the editor and articles in national and state journals, and as I travel about the state talking with physicians frequently I get the impression that "they" should be doing a lot more to make the life of the practicing physician easier. The generic "they" that people refer to is, I

Continued on facing page

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presume, the leadership and the active participants in the committees of our state and national societies.

The challenge I present to all of you as members of MSMS is, 'What are *you* doing to fix the health care delivery system? Are you involved in county, state, or national level efforts to bring about changes which will allow you to practice high quality medicine in a system which is concerned about the patient's well-being? Do you go to your component society meetings and take your turn being active in various projects? Have you taken a turn as a delegate to the state medical society or as a member of an MSMS committee? Brought your concerns to your hospital medical staff section?

I raise these questions because I sense we have a lot more members who are content to offer as their major contribution the writing of a letter critical of some action. They fail to recognize that we are only as strong as the number of members working for the common good of the organization and of our patients.

If you are not an active fixer, supporter or adviser to those who are trying to fix the delivery system, I would hope that you're not critical when the vehicle spits, coughs, chokes and grinds to a halt. This could happen despite the best efforts of a small group of physicians who are devoting their time on behalf of us all, over and above what is required of them in their own practice situations, and without compensation. It is being done because the fixers have a deep interest in the preservation of a high quality delivery system for our patients and for physicians, regardless of each physician's contribution to organized efforts.

Think about it. Can you fix it all by yourself? □

More on Newberry doctors

Just a short note of additional information concerning "Newberry's amazing doctor production," by Doctor Grennan (p. 74, February *Michigan Medicine*).

There are currently four medical students from the area: Andres Rodriguez, a junior at Yale Medical School; Michael Ennis, a sophomore at Michigan State University (CHM); Tom Brennan and David Michelin, freshmen at Michigan State University College of Human Medicine. Sarah Michelin is finishing her last year at the College of Veterinary Medicine at MSU. I do no know of any other veterinarians.

Another minor clarification on the article is that these people were all "Newberry-schooled" not necessarily "Newberry-bred."

When you look at the current amount of debt a medical graduate has, I'm not sure it is courage that it took. As a parent, I hope my kids do not become like the farmers.

I thank Doctor Grennan for his continuing interest in Newberry.

As a hospital board trustee, I pass on that in spite of this doctor production, Helen Newberry Joy Hospital is in need of one or two family doctors, preferably willing to do some OB.

Thank you for printing the article. We do feel Newberry is a special place to live.

Lois Michelin
Newberry

HCFA celebrates a decade

This letter recently was received by MSMS Executive Director, Bruce Ambrose:

On March 8, 1987 the Health Care Financing Administration was ten years old. The celebration of this anniversary gives you and me the opportunity to reflect on the past and also plan for the future.

In the past your organization and ours worked aggressively to assure that the health care needs of elderly, poor and disabled Americans were met. To a large extent I believe these efforts have been successful.

As this point in time I especially wanted you to know that our organization is committed to work with you to assure quality health care for our country in the future.

Barbara J. Gagel
Regional Administrator
Health Care Financing
Administration, Department of
Health and Human Services

More letters, next page

Fish consumption advisory

Some physicians may have recently heard or read about the 1987 sport fish consumption advisories released by the Michigan Department of Public Health. These advisories, which are updated annually, are intended to assist fish consumers in reducing their exposures to potentially harmful chemical contaminants present in some fish from certain lakes and streams. A copy of the Department's "Fish Preparation and Consumption Guide" is being provided as a tear out pamphlet at the front of this journal. After review of this pamphlet, physicians may want to consider posting it in their patient waiting area or examination rooms as an information source for patients.

Not only does the pamphlet provide some general guidance for fish consumers relative to reducing contaminant levels in fish which are eaten, but it also lists fish species from specific waterbodies known to have chemical contamination at levels of public health concern. Depending upon the specific situation, contaminants may include PCB, chlordane, dieldrin, dioxin and mercury, as well as many others at lower levels. The problem is not unique to Michigan.

The presence of chemical contaminants in fish presents a dilemma because fish represent a nutritious food source for humans and regular consumption of fish has been shown to be influential in the prevention of certain coronary diseases. Thus, we are forced to balance the known positive health benefits against the often uncertain negative chemical exposure impacts. Ideally, educational efforts will result in informed consumers who will select the least contaminated fish species and sizes and utilize methods of preparation and cooking which can minimize their exposure to contaminants.

Through studies of Michigan residents who eat varying amounts of Great Lakes fish, our Department has found a positive association between the consumption of contaminated fish and the elevation of human body burdens of fat soluble contaminants found in fish. We also demonstrated that consumption of a single meal of highly contaminated fish results in a rapid increase in contaminants in the blood stream. For some contaminants, maximum concentrations approached an eight-fold increase over study participants' background levels within six hours following the meal. By one week after the single meal of fish, blood concentrations had declined to the pre-meal levels. Although a portion of the contaminants are being excreted or metabolized, some percentage is undoubtedly retained within the body in adipose tissue and certain organs. Each successive exposure likely results in a net increase in the total body burden.

Many of the contaminants found in fish have acute or chronic toxicological properties as shown by laboratory studies of animals exposed to high doses. In humans, we do not know whether there is a critical level which may be reached from long-term consumption of fish, above which toxic effects may occur. We have shown that fat soluble contaminants appear in breast milk and can cross the placental barrier. The significance of such exposures to the fetus and infant has not been fully evaluated but this remains a continuing concern. Because of the unknown impacts on reproduction and child development, physicians involved with pre- and post-natal care should be aware that the Department advises that pregnant women, nursing mothers, women who anticipate bearing children and children age 15 or under should not eat fish known to be contaminated.

Further information or additional copies of the "Fish Preparation and Consumption Guide" may be obtained by calling the Department's toll-free Toxics and Health Hotline, 1-800-648-6942. ☐

John L. Hesse, MS
Administrative Assistant, and
Daniel E. Williams, MD, MS
Medical Consultant,
Center for Environmental Health
Services, Michigan Department
of Public Health

Women physicians' committee an incubator for upcoming leaders

By Vivian M. Lewis, MD

The idea to have a permanent MSMS committee to address the concerns of women physicians was the brainchild of Linda Logsdon, MD, of Southfield. In her own involvement in organized medicine she had found few women in leadership roles. An appeal was made to the chairman of the MSMS Council (now Board of Directors) and an ad hoc committee was formed. From its inception both men and women have been members. After a successful initial year, the committee was made a standing committee.

From the beginning, the committee has been concerned with getting more women physicians involved with organized medicine for a variety of reasons:

To involve all physicians in solutions to the crises that the profession of medicine finds itself in today.

To create a new pool of potential leaders to enrich the workings of our local and state organizations.

To make women physicians feel "welcome" in the organization.

To encourage medical students and residents to participate.

To encourage continuing educational achievement through the programs of MSMS.

To provide opportunities for networking for committee members.

The committee has carried out these goals by sponsoring annual workshops, providing speakers for small groups, circulating information pertinent to women physicians and encouraging the appointment of women to committees and task forces of MSMS. In addition, the committee has sponsored programs at the past two MSMS Annual Scientific Meetings. A very successful networking breakfast was held prior to the 1986 meeting.

In the long run, we hope that the need for the committee will cease to exist, because women MSMS members will want to participate and will be expected to participate in the every facet of our organization. We feel that we are moving in that direction, with evidence of more women participating throughout the organization. It should not be long before our expectations are realized. ☐

The author, Doctor Lewis, is chairperson, MSMS Committee on the Concerns of Women Physicians.

Doctor Lewis

> "From the beginning, the committee has been concerned with getting more women physicians involved with organized medicine."

Editor's note:
We posed these questions to a half dozen women physicians: "Should women physicians have separate programs or take part in the mainstream of organized medicine? Which approach appeals to most of you? Why?"

Their responses are on the pages that follow.

Women's concerns addressed as MSMS evolves

By Rhoda M. Powsner, MD

I answer the editors' question by rephrasing it to read "Should women physicians have separate programs to allow them to more fully take part in the mainstream of organized medicine?"

The practice of medicine involves continuing education. This was the case before the phrase "Continuing Medical Education" was formalized as part of the legislative reform dealing with the "malpractice crisis" of the 1970s, and has been the primary function of most of our associations and specialty organizations.

Should special concerns and problems of women physicians be dealt with? Of course they should. They should be handled just like the problems encountered by all physicians, be they general or specialty interests, concerns about the malpractice crisis, assistance with setting up a practice, hospital-medical staff issues—all of which have required setting up special programs.

The author, Doctor Powsner, is chairperson, MSMS Committee on Medical Licensure and Discipline.

Doctor Powsner

Women *are* part of the mainstream of organized medicine. As a numerical, and therefore as a political force, they are disadvantaged especially in such formidable associations as the AMA, and their frustration in that milieu is obvious. But this does not seem to be the case in county and state societies where women are, in increasing numbers, state society presidents, speakers of the houses of delegates and delegates and alternate delegates to the AMA.

MSMS should be looking at the needs of all its members and be prepared as our state medical society to meet as many of them as possible. By virtue of attention to such detail our programs become more diversified as the practice of medicine continues to evolve. The solutions necessary to enable women to take a more active part in organized medicine will be a natural part of the process. □

AMA Women in Medicine Project

The number of women in medicine has increased dramatically in the past decade. Today women comprise 13 percent of all physicians (compared to eight percent ten years ago), almost one-third of the medical student body, and nearly one-fourth of all resident physicians.

Despite their rapid growth in numbers, women have not been as involved in organized medicine as men. Currently only 27 percent of female physicians join AMA, compared to 46 percent of male physicians. Recognizing the need to increase the involvement of women at all levels of organized medicine, the American Medical Association Board of Trustees in June 1984 approved a Women in Medicine Project.

Reasons for low participation should be explored

By Cathy O. Blight, MD

An old boys organization — maybe. But the faces of AMA, MSMS and the county societies are changing. As more and more women enter medicine, the make-up of organized medicine must change to meet the challenge of the future.

Women are not joining these organizations in proportion to their numbers in the profession. Yet they don't seem to be joining the "all-women" organizations, either. Something like 27 percent of women physicians belong to the AMA and/or their state societies, yet only eight percent belong to American Medical Women's Association. Obviously medical organizations need to explore the reasons why.

The reasons are probably as varied as the physicians themselves. A few main reasons might emerge, however. I think that in this day of liberation, many of the nurturing functions in a family still fall on the woman. With maternal instincts and all, we still bear a tremendous guilt about not being able to fulfill all our obligations. Many younger women were taught that they could be "superwoman" and have "it all," and it just isn't the case. Support systems for these women are not in place to allow them to do it.

Doctor Blight

Another reason for women's low participation could be that they feel uncomfortable taking a leadership role. I don't think that this is just a concern of women but of many young physicians.

Finally, many see organized medicine as an "old boys club" with a different agenda than what they might have. This may be true, but significant change does not come by standing on the outside, railing against the establishment. It comes by rolling up one's sleeves and pitching in and working for change.

I do not believe in separate programs or agendas for women physicians. The future of medicine is at stake and we must work together as a whole to protect quality patient care. At the present time, the AMA and its component organizations are recognized at "the voice" of medicine. Only by becoming active in this organization can women have an impact on the future of medicine and health care in this country.

Ideas on how to help: devise times that are convenient for women to have meetings and conferences, provide child care at meetings and leadership training workshops for *all* physicians. ☐

The author, Doctor Blight, is chairperson, MSMS Committee on Membership Recruitment and Retention.

The time for distinctions has passed

By Susan E. Adelman, MD

MSMS poses the question of whether to "mainstream" women physicians in organized medicine or whether we should be offered separate programs. "Mainstreaming" is the term used when talking about putting the mentally retarded into regular classes in school. Viewed in this context, I am inclined to object to the comparison. By the same token, I object to being called a *woman* doctor, as contrasted with a doctor. I have the same objection to being called Mrs. in a social situation, when a male physician would be called doctor.

The author, Doctor Adelman, is chairperson, MSMS Liaison Committee with Blue Cross Blue Shield of Michigan, and a member, MSMS Board of Directors.

Doctor Adelman

The time has passed for these distinctions. Women, blacks or other subgroups of the medical community should not be separated out from the rest of organized medicine, unless it is for a temporary committee or task force to address a specific, timely issue. Most of the issues that currently interest women physicians, however, are the same ones that interest male physicians. The talents that women bring to medicine and to medical politics are the same as those that talented men bring to clinical practice and to medical politics. I see only disadvantages in separating out women, just as I see disadvantages in separating primary care physicians from specialists, town from gown, or employed from fee-for-service physicians. Certainly we have enough fragmentation in medicine already. Now is the time for doing things together. ☐

Women MDs numbers growing

The proportion of female physicians within the physician population is growing. From 1970 to 1981, the percentage of female physicians increased from 7.7 percent to 12.2 percent. Correspondingly, 16.3 percent of physicians under the age of 45 in 1981 were female compared with 7.7 percent of physicians over 45 years old.

Female physicians are also relatively concentrated in certain specialty groups. In 1981 females comprised 8.9 percent of general/family practitioners and 5.6 percent of surgeons, in contrast to 15.4 percent of medical specialists and 15.1 percent of other specialists.

Blended approach builds support system

By Natalia M. Tanner, MD, FAAP

It is extremely important for female physicians to have high visibility in organized medicine and to participate in decision- and policy-making positions. If females are not in the "mainstream," then they are uninformed and cannot bring to a male-dominated organization the female physician's perspective.

In addition to participating in the mainstream, female physicians should have committees, groups or sections devoted to their specific concerns such as the development of leadership skills; media training; how to compete in the present day market; working hours; child care; maternity leaves; split or shared residencies; opportunities for job placement; role modeling and recruitment.

Females often need reinforcement of self-image to compete in today's changing health care delivery system. Women also need to know that organized medicine can play a great role as a support system. I strongly advocate that male members of organized medicine serve on female group committees, task forces and sections devoted to women's concerns.

Both opportunities should be available: mainstream participation in decision-making, and organized group support within the parent organization to give specific direction to women's concerns.

The author, Doctor Tanner, is a member, MSMS committee on the Concerns of Women Physicians.

Doctor Tanner

In the early years of my professional career very few females participated in organized medicine, and I felt very isolated, but not intimidated by male dominance. The formation of task forces, committees and sections on concerns of women has added meaningful support for continued participation and has provided many opportunities for role modeling and to serve as a mentor for younger female physicians.

MSMS is to be congratulated on past and continued support of female leaders within our organization. ☐

Do women MDs give patients more time?

Women physicians not only spend more time with their patients than do male physicians, they also counsel their patients more, several new studies say.

One study from the National Center for Health Statistics found that women MDs spent an average of 17 minutes with each patient — about four minutes more than their male counterparts did.

The other study, from the Boston think-tank Health Economics Research, found that women physicians also counsel their patients more. "Women may provide higher quality care than men," said the study director of the Health Economics Research group in an interview with *The Wall Street Journal.*

Researchers involved in both studies noted, however, that these factors partially come from the fact that women physicians have more time on their hands. Women physicians tend to see fewer patients, are "less aggressive" about building their practices, and meet resistance from prospective patients, the studies noted. ☐

The “mainstream approach” works

By Dawn E. Springer, MD

When I entered medical school initially in 1961 as one of very few women at the University of Michigan, I did not then experience any great degree of discrimination by my peers or the faculty. When I resumed my medical education at MSU in 1974 I experienced no significant problems and felt quite comfortable and included in a well-rounded education. I remained in the Lansing community as part of the Family Practice Residency Program at Sparrow Hospital, then located in Mason with Shirley Robertson, MD, where I continue in private practice. I also continued my affiliation with the Residency Program as a part time community faculty director and have joined numerous medical organizations. Also, I sit on a number of boards of local medical organizations.

My experience in the mainstream of medicine in my community and state has been quite positive and I feel that working in this arena rather than approaching medicine from a separatist area has been more beneficial to me, and to my colleagues—male and female.

I do believe that the women who have chosen to remain separate from their male colleagues and to adapt a defensive, almost antagonistic approach because of perceived or real discriminations, are doing themselves and women in general a disservice.

In a relatively short period of time I have become involved in many organizations. Perhaps I am fortunate because I live and practice in a community where I have been openly welcomed. With a friendly cooperative attitude, women can do as well as (or possibly better than!) men in organized medicine. ☐

The author, Doctor Springer, is a member of the MSMS Committee on the Concerns of Women Physicians.

Let’s demystify women

By Diane A. Culik, MD

The history of all newcomers (the Irish, Germans, Eastern Europeans, Blacks) has shown that separate organizations must work to do two things: 1) demystify the newcomers to the culture, and 2) use the de-mystified status to normalize the behavior of the mainstream toward more of its members. Both the newcomers and the mainstream gain strength from each other. The rich diversity of American culture stems from such a process.

The case of women in medicine is no different from any other group of newcomers. We must go through this process of individuation and identification. We can’t isolate ourselves, and just as importantly, we can’t diversify the mainstream without the separate programs that demystify women.

This sounds like a slow and tedious process because it is. The real question is how to bring together a mass of “newcomers” and “mainstreamers” willing to do the work. If enough physicians (male and female) nurture the growth of their profession, medicine will again prove its vitality.

The author, Doctor Culik, is director, Family Practice Residency, Family Medical Center, Detroit.

On the socioeconomic practice characteristics of women

A report from the AMA

This article is an excerpt of a report by the AMA Center for Health Policy Research:

Studies by Kehrer and Langwell (*Journal of Human Resources*, 1976 and 1982 respectively) have indicated that, in addition to differences in their age and specialty distributions, there are differences in the socioeconomic practice characteristics of male and female physicians. This report provide further information on the socioeconomic characteristics of male and female physicians.

Practice characteristics

Female physicians were less likely to be self-employed and, on average, practiced fewer hours and had fewer patient visits per week than their male counterparts in 1983. The share of female physicians who were self-employed was 26.4 percent smaller than among male physicians. Female physicians on average worked 7.9 percent fewer hours and saw 18.5 percent fewer patients per week than male physicians.

The lower percentage of self-employed physicians among females may result in part from differences in the age distribution of male and female physicians. Among age groups, the differential in the likelihood of self-employment is largest for physicians 40 years of age or younger, and smallest for physicians over the age of 55. This may be explained by the greater potential for career interruptions among female physicians (e.g., for child bearing and rearing). Since career interruptions are likely to be more costly for self-employed physicians because of the foregone returns to the investment in developing a practice, younger females may prefer to practice medicine as employees to avoid these costs.

For the most part, differences in hours and visits are not attributable to differences in specialty and age distributions. Indeed, in many cases the differences between female and male physicians are larger for physicians within similar specialty and age groups. Among surgeons, however, there was no significant difference in hours worked between females and males. The difference in total visits was smaller for employee physicians than for self-employed physicians.

Earnings differences

Female physicians, on average, earn less from medical practice than male physicians. The average net income (income after expenses but before taxes) of male physicians in 1982 was $102,000, compared to $65,200 for female physicians. Part of this income differential is attributable to differences between female and male physicians in hours practiced, specialty, age, and employment status. For example, as noted previously, females tend to work fewer hours than males. Thus, adjusting income for hours of practice reduces the magnitude of the earnings differential. The difference in average net income per hour of practice between male and female physicians in 1982 was 24 percent, compared to the 36 percent difference in average net income before adjusting for hours of practice.

The differential also narrows in most cases if the average net income per hour of practice for female and male physicians within the same specialty are considered. At least part of the remaining differential results from differences in the age distribution of female and male physicians.

Since self-employed physicians have higher average earnings than employee physicians, the earnings differential may also reflect differences in employment status between male and female physicians. In 1982 among self-employed physicians females earned 18 percent less per hour than males. Among employee physicians, females earned 21 percent less per hour than males. Both of these earnings differentials are smaller than the 24 percent differential in earnings per hour before adjusting for employment status.

Differences in earnings between male and female physicians that remain after accounting for differences in hours of practice, specialty, age and employment status may result from a variety of factors, such as dif-

Continued on next page

CHARACTERISTICS/Continued

ferences in case-mixes and board certification status.

Finally, to determine whether the gap in earnings between male and female physicians has increased or decreased over time, differences in rates of growth in net practice income and net income per hour are examined. For female physicians, net income increased from $27,600 in 1972 to $65,200 in 1982 — an average annual rate of increase of 9.0 percent. For male physicians, the average annual rate of increase in net income was 7.9 percent over the same period. In terms of income per hour, the average annual rate of growth from 1972 to 1982 was 6.8 percent for female physicians and 6.2 percent for male physicians. Moreover, the rates of growth in both net income and net income per hour are higher for females than males within all four specialty classifications and two of three age groups. Thus, the earnings differential between male and female physicians appears to be closing slowly over time. ☐

Women look to MSMS for answers

When planning a management skills workshop, the MSMS Committee on the Concerns of Women Physicians polled female physicians on their interests. Respondents indicated high interest in topics like time management, stress management and public speaking. In addition, they asked for more information on the following:

- Effective pathways to participation at decision-making levels.
- Office management.
- Networking.
- Managing family and career effectively.
- Financial management for the single person.
- Getting help in the daily management of the family.
- How to improve cash flow and collection.
- Computers in private practice and personal use.
- Love and romance for the single female physician — reality or fantasy?
- Publish or perish basic scientific writing.
- Childcare resources.
- Sexism in the medical profession.
- Adequate household help.
- Developing leadership/administrative skills i.e. breaking into the "old boys network." . . . Development of an "old girls network."
- Personnel management.
- Coping with professional insecurity. ☐

Listening: bridge to dialogue, gateway to healing

By Linda L. Albert

In recent years, and in certain ircles, the concept of "listening" as been undergoing a face lift, oing far beyond the passive apearance of keeping one's mouth hut and letting someone else do he talking, which is what most f us recognize as "listening."

Although listening is actually he foundation of the communiation process, most people have ot had the advantage of any real nstruction in it. Research shows hat we are taught communicaion skills in school in inverse proportion to need in life—with writing heading the list, reading text, some speaking and virtually no training in listening. Even in hese days when many medical chools are teaching interviewing echniques (and what one physiian described to me somewhat disparagingly as the "warm uzzy" aspects of medical educaion) listening often turns out to be the step-child of the communication process.

This article is a plea to adopt he child into the family.

John Naisbett, author of *Megatrends*, coined the phrase, "High Tech-High Touch" to illustrate he need in present society to complement complex technology with the human and nurturing aspects of life in order to satisfy our inner hungers for balance. Where more appropriate to expand on this theory than in medicine?

Ms. Albert

"How we can communicate contributes either to our feelings of well-being or compounds our sense of dis-ease."

So what do I mean by listening? Listening is an active, assertive, nondefensive, self-chosen process, involving a variety of learned skills in which we engage for a variety of purposes. These key points are crucial:

- First, listening is a choice. If you stop to think about it, no power on earth can make any of us listen if we choose not to.
- Second, real listening is geared toward understanding the message *as the speaker intended it*. Commonly, the meaning of a communication is the response that we get regardless of our intention.
- Third, we must be willing to revise our culturally conditioned, often unconscious belief that to listen means to agree or to obey. ("You're not listening to me" typically implies that, "You're not agreeing with me or doing what I want you to do." The fascinating point to consider is that if I believe that I've been heard, there's a good chance that ultimately I won't mind if you don't agree or cannot do what I want.)
- Fourth, it must be noted that we can only listen with accuracy to others to the extent that we are willing to listen to ourselves.

Listening pioneer, Lyman K. Steil has developed a four-stage listening model called the SIER Model. The SIER—Sensing, Interpreting, Evaluating and Responding—is used to teach the hierarchiacal nature of the listening process. To be an effective listener, those four stages have to be passed through one at a time. Many of our errors come from unwittingly failing to do this.

Hearing for example, is only the first stage of the listening process and comes in to us as raw

Continued on next page

The author, Ms. Albert, is a communications consultant specializing in listening training, and conducted a workshop at the April 11 MSMS Leadership Skills Conference for Better Communications, sponsored by the Committee on the Concerns of Women Physicians.

data: sounds and words. Because we are least conscious of this first stage we tend to tie the sensing, interpreting and our emotional response together. As a consequence, we end up with what *appears* to be the truth instead of understanding that it's more often our unique interpretation of the truth with room for other realities or viewpoints.

Words themselves are not absolute. (For the 500 most used words in the English language there are 28,000 dictionary definitions!) So meaning, as it turns out, lies in people, not in words. It is in the evaluating stage that we decide how we feel about the message, whether we agree or disagree, and what we will or won't do about it.

The response stage puts listening where it belongs, as an integral back-and-forth part of the communication process. Sad to say, a lot of what passes for dialogue in this country is really "duologue"—two monologues going on side by side.

Complications

Why do things between people get so complicated? Obviously the reasons are many and complex. Sometimes communication failures are committed unwittingly.

Howard B. Beckman, MD, and Richard M. Frankel, PhD, conducted a two year preliminary study on the "Effect of Physician Behavior on the Collecting of Data" at Wayne State University School of Medicine in Detroit. (*Annals of Internal Medicine*, Vol. 101 No. 5, November, 1984.) In soliciting patients' concerns at the outset of a clinical encounter, only 23 percent of the patients in the study were able to complete their opening statement of concerns. The rest were interrupted by their physicians (residents in primary care internal medicine and two instructors) in an average time of 18 seconds after starting to speak!

> **"Sad to say, a lot of what passes for dialogue in this country is really 'duologue' — two monologues going on side by side."**

The doctors weren't being rude. In fact, they were doing their jobs as taught. Once the physician takes over, though, the researchers conclude most patients are never able to regain control. Thus, sometimes vital information gets lost, or at best, is offered as the patient is walking out the door, leaving everyone frustrated. Beckman and Frankel suggest that since patients are not trained in diagnosis, it's an error to assume that the first complaint is always going to be the most important one. Further, because of the traditionally asymmetrical or "parent-child" relationship between doctors and patients, many patients are intimidate and find it difficult to speak u or to take the communication i a direction that the physicia doesn't seem to want to go.

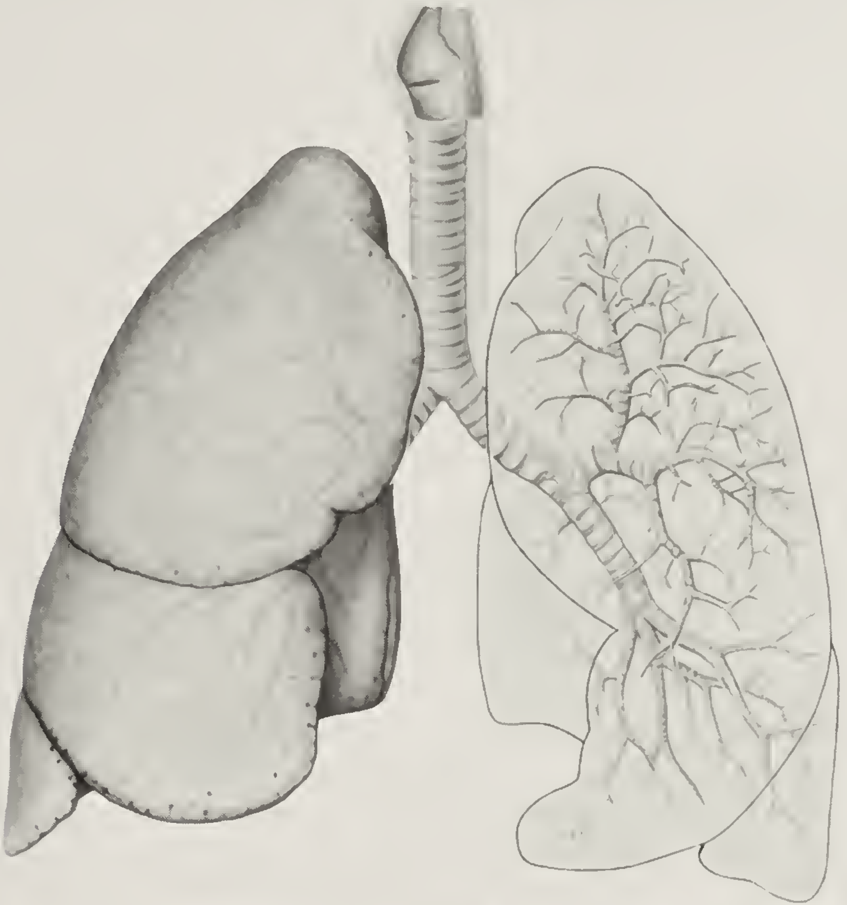
A remedy

In an effort to remedy this medical students at Wayne Stat are being taught to use what call "following or non-reflectiv listening skills" during the opening stages of a clinical visit, instead of jumping in with questions, statements or eve recompleters before the patien has had his or her initial say. Although Doctor Beckman told m that this feels like *not doing* t many action-oriented physicians, and is therefore hard to teach, th results appear to be more satisfactory for the medical practitione in obtaining necessary information for diagnosis and for the patient in feeling heard. Further, time does not seem to be a problem. The longest opening statement on the part of a patient no interrupted in the study was 150 seconds.

The subjective sense of feeling heard has larger implications than just the practical ones. How we communicate contributes either to our feelings of health and well-being or compounds our sense of loneliness and dis-ease. (See James J. Lynch, *The Language of the Heart—The Body's Response to Human Dialogue*, 1985, Basic Books, Inc.

Continued on page 222

Consider the causative organisms...



Ceclor®
cefaclor
250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary Consult the package literature for prescribing information.

Indications and Usage Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings IN PENICILLIN-SENSITIVE PATIENTS CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by C *difficile* Other causes of colitis should be ruled out

Precautions *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued and, if necessary the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly) There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers – Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology they are listed below to serve as alerting information for the physician

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic – Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note Ceclor® (cefaclor Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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New York.) In some cases, according to current research, dysfunctional communication patterns and the transactional nature of human communication eventually can take their toll in disease and shortened lives.

Promising therapy

At The Center for the Study of Human Psychophysiology at the University of Maryland School of Medicine, psychologist Lynch and his colleagues have developed a creative and promising therapy for the treatment of hypertension, migraine headaches and related disorders. Having participated in their workshops, I am convinced that, hypertensive or not, few of us have been educated or nurtured to communicate as well as we might.

It is for this reason I am interested in listening as a "bridge to dialogue and a gateway to healing." By dialogue I mean mutual, open-to-feelings, spontaneous talk. I distinguish, as do Doctors Reiser and Rosen in their book, *Medicine as a Human Experience* (Aspen Publishing Co., Rockville, Maryland) between healing and curing. Healing, according to the dictionary, means "to make whole, bringing to an end or conclusion (as in conflicts within or between people), reconciling—rather than taking care of, taking charge of, fixing or curing."

"Evidence is mounting that there are payoffs in the forms of improved information gathering, error reduction, the saving of time and money. . ."

To open one's mind to another, to set aside one's opinions, prejudices, agendas, ideas, beliefs and interpretations long enough to hear someone out; to do one's best to glimpse that person's view of the world and allow him or her the right to have it, even if it differs from one's own, are key ingredients in genuine listening. And evidence is mounting that there are payoffs in the forms of improved information gathering, error reduction, the saving of time and money, stress and conflict resolution and/or prevention, team building, relationship building and in healing.

Important research is taking place at UCLA in conjunction with the Rand Corporation. Researchers were investigating health outcomes as they are tied in with more human and symmetrical doctor-patient relationships. Sheldon Greenfield, MD, and Sherrie Kaplan, PhD, MPH, reported their findings at a recent conference I attended sponsored by the University of South Florida School of Medicine. Results indicate that when patients were given more information, educated to understand options and empowered to participate in decision-making, the patients' perceptions of their abilities to function improved, symptom levels decreased and compliance increased. Control groups did not do as well in any of these areas. On top of this, the time required for patient visits remained the same.

The psychologist Abraham Maslow has been quoted as saying that if the only tool we have in our tool box is a hammer, we will treat the whole world as though it were a nail. At its best, listening is a remarkable and versatile tool. We are living in a time of incredible change, incredible pressures and if we hang on, equally incredible possibilities.

If human dialogue is the "language of the heart," then listening is the *heart* of language. It is, therefore, time to realize the power of healing communication and to take the next step. ☐

To show you how many hypertensives stayed on INDERAL® LA (PROPRANOLOL HCl) after a major nationwide trial...

...we had to find just the right room.

0,073 patients (90%) who started on NDERAL® LA stayed on INDERAL LA.[1*]

urprising? Not really.

Because most patients on INDERAL LA (propranolol HCl) don't even know it's working.

A recent double-blind, placebo-controlled, crossover study in 138 hypertensive patients[2] revealed that INDERAL LA has a side effects profile unsurpassed by atenolol or metoprolol—which shows how well-tolerated once-daily INDERAL LA can be.

ole therapy or concomitant therapy? ifty-nine percent of the time, INDERAL LA stood on its own.

The patients in the nationwide compliance trial were no different from yours. Generally when the antihypertensive regimen is complicated, compliance may become a problem. So, the effectiveness of INDERAL LA as once-daily monotherapy is a big plus. Of the remaining hypertensives in the program, 36% were controlled merely with the addition of a diuretic to INDERAL LA.

or the noncompliant patients in your practice, INDERAL LA may ell be the answer.

Almost 20,000 of the patients in the nationwide compliance trial were identified as having been noncompliant with their previous antihypertensive therapy. Their physicians reported that 88% showed improved compliance when placed on once-daily INDERAL LA.

Control, comfort, and compliance

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

*After a 30-day trial with INDERAL LA, physicians reported that 90% of the patients would remain on INDERAL LA.

The one you know best keeps looking better

Please see next page for brief summary of prescribing information.

The one you know best keeps looking better

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride Inderal LA is available as 80 mg 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use Effects on plasma volume appear to be minor and somewhat variable INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate systolic blood pressure, and the velocity and extent of myocardial contraction Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient But there are also situations in which sympathetic stimulation is vital For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

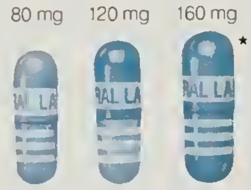
Propranolol is not significantly dialyzable

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl)

LONG ACTING CAPSULES



INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation Clinical improvement may be temporary

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS. CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible)

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted, however, that the impaired ability of th heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia an surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-recep tor agonists and its effects can be reversed by administration of such agents, e g , dobutamin or isoproterenol However, such patients may be subject to protracted severe hypotensio Difficulty in starting and maintaining the heartbeat has also been reported with beta blocker

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearanc of certain premonitory signs and symptoms (pulse rate and pressure changes) of acu hypoglycemia in labile insulin-dependent diabetes In these patients, it may be more difficult adjust the dosage of insulin

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptom of hyperthyroidism, including thyroid storm Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have bee reported in which, after propranolol, the tachycardia was replaced by a severe bradycardi requiring a demand pacemaker In one case, this resulted after an initial dose of 5 m propranolol

PRECAUTIONS. *General* Propranolol should be used with caution in patients with impaire hepatic or renal function INDERAL (propranolol HCl) is not indicated for the treatment hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure Patients shou be told that INDERAL may interfere with the glaucoma screening test Withdrawal may lead to return of increased intraocular pressure

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart diseas elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as rese pine should be closely observed if INDERAL is administered The added catecholamine blocking action may produce an excessive reduction of resting sympathetic nervous activit which may result in hypotension, marked bradycardia vertigo, syncopal attacks, or orthostat hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals hav been conducted to evaluate toxic effects and carcinogenic potential In 18-month studies both rats and mice employing doses up to 150 mg/kg/day there was no evidence of sign cant drug-induced toxicity There were no drug-related tumorigenic effects at any of th dosage levels Reproductive studies in animals did not show any impairment of fertility that wa attributable to the drug

Pregnancy Pregnancy Category C INDERAL has been shown to be embryotoxic in anima studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women INDERAL should b used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers INDERAL is excreted in human milk Caution should be exercised whe INDERAL is administered to a nursing woman

Pediatric Use Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarel required the withdrawal of therapy

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypoten sion, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually of th Raynaud type

Central Nervous System lightheadedness mental depression manifested by insomnia lassitude, weakness, fatigue, reversible menta depression progressing to catatonia, visua disturbances, hallucinations; an acute revers ible syndrome characterized by disorientatio for time and place, short-term memory loss emotional lability, slightly clouded sensorium and decreased performance on neuropsych metrics

Gastrointestinal nausea, vomiting, epigas tric distress, abdominal cramping, diarrhea constipation, mesenteric arterial thrombosis ischemic colitis

Allergic pharyngitis and agranulocytosis erythematous rash, fever combined with aching and sore throat, laryngospasm and respirator distress

Respiratory bronchospasm

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been re ported

Miscellaneous alopecia LE-like reactions, psoriasiform rashes, dry eyes, male impotence and Peyronie's disease have been reported rarely Oculomucocutaneous reactions involvin the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have no been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in sustained-release capsule for administration once daily If patients are switched from INDERA tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeut effect is maintained INDERAL LA should not be considered a simple mg for mg substitute fo INDERAL INDERAL LA has different kinetics and produces lower blood levels Retitration ma be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

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ANGINA PECTORIS — *Dosage must be individualized* Starting with 80 mg INDERAL L once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained Although individual patients may respond at any dosage level, th average optimum dosage appears to be 160 mg once daily In angina pectoris, the value an safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (se WARNINGS)

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PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group are to limited to permit adequate directions for use

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REFERENCES:

1. INDERAL LA National Compliance Evaluation Program Data on file, Ayerst Laboratories
2. Ravid M, Lang R, Jutrin I The relative antihypertensive potency of propranolol, oxprenolo atenolol, and metoprolol given once daily *Arch Intern Med* 1985, 145 1321-1323

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HEF fund drive off to rousing start

By Bruce W. Ambrose, MSMS executive director

Gifts and memorial contributions in late 1986 spurred new activity by the MSMS Health Education Foundation (HEF), and three new board members have added new perspectives to its commitment to encourage healthier ways of living.

Arthur L. Tuuri, MD, Flint, and Henry Domzalski, MD, Detroit, are new physician members of the HEF Board, and the Rev. Bertram W. Vermeulen, Fremont, joined the board in January as one of the non-physician members.

First among the actions of the restructured board was to press forward in its efforts to achieve a corpus sufficient to achieve the goals of the Foundation. The generous response from members of the medical society in December encouraged the board to once again go to the membership for contributions.

An MSMS *Medigram* soon will carry another contribution request and return form for use by contributors.

Program funding

Meanwhile, the Foundation is providing funds for continuous evaluation of an Oakland University study of fitness programs for office employees. Requests also have been received for assistance in programs of drug abuse among pre-adolescents, health and nutrition programs for school students and bioethical concerns in medicine. The Foundation also continues its support of medical school students through its restricted Bruce Fund and in response to direct requests.

> **“If we can demonstrate that doctors of medicine are willing to support healthy living habits we can seek funds from non-physician enterprises.”**

“Our initial efforts were so successful that we believe there are many more physicians out there who would like to join us in this exciting endeavor,” said John R. Ylvisaker, MD, president of the Foundation. “That is why we are coming back again. If we can demonstrate to the non-physician community that doctors of medicine are willing to support healthy living habits, then we can also seek funds from non-physician enterprises.

“Our achievement in 1987, in addition to ongoing programs already funded, ought to be to increase our general fund by $100,000. We have been unusually fortunate in our investment strategies (in 1986 the general fund of the Foundation increased by 11 percent) but further contributions will be necessary to reach that goal.”

Doctor Domzalski, one of the new board members, is in private practice of urology in Detroit, and represents the Wayne County Medical Society on the MSMS Board of Directors. He has served as president of WCMS and serves on the MSMS Board’s reference committee on finance.

Doctor Tuuri is a retired pediatrician in Flint. He originally moved to Flint under contract with the C.S. Mott Foundation to provide medical services to indigent children, and when that program grew to become the Mott Children’s Program he became its director. He now also serves as president of the Flint Health Foundation.

Rev. Vermeulen is president of the Greater Fremont Foundation. He served as minister of the Fremont United Methodist Church until assuming the Foundation leadership. The Greater Fremont Foundation provides assistance to indigent individuals in Newaygo County.

Following is the honor roll of HEF contributors.

Memorial contributions in honor of:

Vernon V. Bass, MD, Saginaw
Rosalie Black, wife of Robert W. Black, MD, Detroit
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Continued on page 230

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Frank B. Walker, MD, Grosse Pointe
John R. Ylvisaker, MD, Bloomfield Hills□

Update: premarital testing

By E. Joseph Alberding, MD

State and national proposals to mandate testing for HIV infection, or AIDS, have raised many questions among physicians as to their legal obligations in performing premarital tests. MSMS has received several inquiries on current premarital testing requirements, and provides the following information as a reminder to members.

The Michigan Public Health Code requires individuals seeking a marriage license to obtain certification from a physician that they are *free from venereal disease in the communicable stage.*

Currently, venereal disease is defined to include syphilis, gonorrhea, chancroid, lymphogranuloma, venereum, and granuloma inguinale. State law permits the Department of Public Health to develop rules which designate other sexually transmitted diseases for which premarital testing and reporting is required. The Michigan Department of Public Health does require cases of AIDS to be reported. The Department does not require premarital testing for HIV. HIV testing remains voluntary, and many education efforts have sought to encourage individuals at high risk for AIDS to seek testing and counseling. □

The author, Doctor Alberding, is chairman, MSMS Liaison Committee with the Michigan Department of Public Health.

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(See Brief Summary of Prescribing Information on the next page.)

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This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks For this purpose occasional use of the sublingual preparations may be necessary

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage When they persist the dose should be reduced or use of the product discontinued In some patients, dermatitis may occur.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest, if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 system every 24 hours Some patients, however, may require the Transderm-Nitro 10 system If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
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10 mg/24 hr	50 mg	20 cm²	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm²	30 Systems (NDC 0083-2115-26) *100 Systems (NDC 0083-2115-30)

*Hospital Pack 100's

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40th YEAR
Postgraduate Medicine

Every Issue is a Celebration of Clinical Information

Board of Medicine received 225 allegations last year

By Thomas J. DeKornfeld, MD

As I promised in my January column, I am going to present to you the regulatory considerations which were before the Board of Medicine during 1986. Actually, this column will address the allegations and investigations, while a later column will deal with the disciplinary activities of the Board and the sanctions imposed on physicians during the last year.

In 1986 a total of 225 allegations were filed with the Bureau of Health Services concerning licensed allopathic physicians in Michigan. These allegations come in all forms, from well-typed letters on impressive letterhead to handwritten notes on legal pads. They may be addressed to the Governor, to the Director of the Department of Licensing and Regulation, to the chairman of the Board or to "whom it may concern." They vary in length from a few lines to 10-12 page missives, closely written on both sides of the page.

All allegations are collected in the Investigation Division of the Bureau of Health Services, which works very closely with the Allegation Investigation Committee of the Board. The investigation Division refers all allegations to the Committee. Some allegations are investigated fully and as a matter of course, since they involve a criminal conviction, a disciplinary action by a sister state, an allegation of substance abuse or an allegation of sexual misconduct. Roughly a quarter of all allegations fell into this category in 1986.

Doctor DeKornfeld

"In general allegations fell into one of three categories. About half of them involved direct patient care issues."

The remaining allegations (165), were carefully reviewed by the committee. Fifteen cases were referred for full investigation, 103 cases were closed since the allegations did not substantiate a violation of the Public Health Code, and 47 cases were returned to the Investigation Division for additional information. The additional information usually requested by the committee is the record from the physician's office or from the hospital. Occasionally, additional information is obtained from the person making the allegation or from the physician against whom the allegation is made. With additional information, 32 cases were closed and the remainder were referred to the Investigation Division for full investigation.

Thus, out of 225 allegations, 78 (35 percent) were investigated and 147 were closed after the Committee felt it had sufficient information to do so.

In general, allegations fell into one of three categories. About half of them involved direct patient care issues, i.e. fell into the negligence-malpractice-incompetence area. A quarter fell into the area of criminal behavior, disciplinary action taken by a sister state, substance abuse and sexual misconduct. The remaining quarter was a mixture of a large variety of issues ranging from fee disputes, personality clashes, the inability to obtain records and insurance billing problems.

Very few, if any, of the latter problems are investigated, since practically none of them constitute a violation of the Public Health Code. The persons who made the allegations are so informed and, if the allegations warrant it, they are referred to

The author, Doctor DeKornfeld, is administrator, Michigan Board of Medicine.

Continued on next page

ALLEGATION/Continued

the county medical society, to the Department of Public Health, to the consumer protection division of the Attorney General's office or to some other agency.

Relatively few allegations

Considering that Michigan has approximately 20,000 licensed allopathic physicians, the total number of allegations is surprisingly small. It is equally surprising that the number of allegations does not seem to change much from year to year. In fact, there has been a small decline in the total number over the last three years. It is even more surprising that the number of meritorious allegations which required full investigation totaled only 78 in 1986. There are three possible explanations: 1. The level of medical care in Michigan is wonderful; 2. The Board is too soft and does not do its job properly; 3. The Board has improved its methods of reviewing allegations; and, 4. Incidents of unsatisfactory care are not reported to the Board.

While I believe that the level of medical care in Michigan is generally quite high, and I know that the Board takes its responsibilities very seriously and closes cases only when it is truly satisfied that there was no violation of the code, I suspect that the third and fourth reasons are the most significant ones. The Board did improve its methods of reviewing allegations and that did reduce the number of allegations investigated. Nevertheless, the primary reason we do not investigate *more* cases is that we just don't get the allegations we should be getting. We get practically no allegations from fellow professionals, either individually or as part of a hospital staff organization, and we get none from professional organizations.

The reason for this is probably a composite of a reluctance to "blow the whistle" on a colleague and an unawareness among consumers that the Board of Medicine and the Department of Licensing and Regulation are charged by statute to receive and act upon such allegations.

Without the help of the profession and the public the Board can not fulfill its responsibilities. Please let us know if a physician becomes a problem by virtue of substance abuse, emotional difficulties or just plain, garden-variety incompetence. Doing so is an ethical and legal obligation.

Not doing so is tantamount to giving your approval and may well leave you in some legal jeopardy. ☐

Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: David Falconer, MD
Action, Date Taken: License limited for one year, fined $2,000 and reprimanded—March 20, 1987
Reason: Wrongfully obtained Demerol for own personal use

Name: Peter Lange, MD
Action, Date Taken: Suspension for one year — March 20, 1987
Reason: Drug diversion/personal use. ☐

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NEW YORK, NEW YORK CITY 6/11-12
RHODE ISLAND, PROVIDENCE 6/25-26

How to handle disposition of a medical practice

By Ruthmarie Shea-Atallah, RN, BS, MA

Disposing of a medical practice can be a happy or sad event. It may come about after months of careful planning or occur suddenly. It may be done voluntarily or without choice. One thing is certain: it will happen.

The process may be implemented by the physician, the spouse or a court appointed administrator. A familiarity with the economic, ethical and legal implications of the procedure is advisable.

A physician who elects to dispose of his or her practice should have relatively little difficulty in doing so. The physician can easily make the judgements and determinations necessary to accomplish the task. In the absence of the physician, however, the spouse or administrator may experience considerably more difficulty pursuing the same aim. Preplanning may be beneficial to all concerned.

Many physicians' spouses assume upon their husbands' or wife's death that they will be responsible for disposing of his or her medical practice. Not necessarily. If the physician has left a will and has nominated his or her spouse as Executor/Executrix of the estate, it is likely that the spouse will be charged with this responsibility. Likely, but not certain. The Probate Court will either approve or disapprove the physician's nomination. Ordinarily, unless there is a compelling reason not to, the person nominated in the will shall be assigned to execute the estate.

If the physician has not left a will the Probate Court will appoint an interested, capable party to handle the administration of the estate. This person may, or may not, be the surviving spouse.

The author, Ms. Shea-Atallah, is a freelance science writer and is administrator, Atallah Heart Center, PC, Rochester.

"Pre-planning the closing of a medical practice may be beneficial to all concerned."

Tip

- Prepare a will.
- Inform spouse of its location.
- Inform executor/executrix nominated of your preference regarding the disposition of your practice.

A medical practice need not die or retire with the physician. A practice has its own inherent value, independent from the physician. It "exists" in leased or owned space. It has equipment, staff, patients and medical records. It can be identified as an autonomous entity. Because many physicians have invested their life's blood into their practices and treasure the warm bonds they have formed with their patients, they find it difficult to dispassionately evaluate their practices.

Stable value

Some view their practices as an extension of themselves, devoid of any value without their presence. "Not so," says Herbert Silverman of Professional Practice Sales, Inc., Southfield. "A medical practice has a certain dollar value which can be calculated. It has been shown that the value doesn't decline when another physician takes over." Silverman is one of the few licensed medical practice brokers in the state, and business is brisk. "Experience has shown me that when a physician dies or retires the patients don't want to leave the practice, if they can avoid it. Their records are there, they know the staff, the surroundings are familiar. They're comfortable."

The key is to make a rapid transition from one physician to another—the sooner the better. "All the new doctor has to do," says Silverman, "is be nice to the patients—develop a rapport. Maintain the same hours and services as the previous physician, and be at least as good a doctor as the one being replaced. In that order. Whatever the practice was worth before the physician dies or retires is what it is worth after, provided the patients are still there." The standard brokerage fee throughout the industry is 10 percent.

Elaine Benson, MBA, of Pointe American Medical Management, St. Clair Shores, agrees. "It is essential that the surviving spouse sells as soon as possible if he or she hopes to get any money out of the practice. Temporary physician coverage must be obtained. If the patients leave there is nothing to sell."

Tip

- Have your practice appraised.
- Update your appraisals every two to three years.
- Arrange a contingency plan for physician coverage, should you be unable to work while your practice is on the market.

Sometimes a practice can't be sold, or sold soon enough. If physician coverage can't be obtained and no buyer is waiting in the wings, steps must be taken to close the practice.

The steps for closing a practice, for whatever reason, remain the same. The objective is to provide a transfer of medical care and responsibility, while insuring that the interests of the patients, as well as those of the physician (or the estate) are preserved.

In order to preserve the interests of the patients it is necessary to inform them that their current physician will be unable to meet their medical needs, refer them to other physicians and provide medical information to their new physicians. The appropriate handling of these matters will preserve the interests of the physician.

Evaluate the needs of each patient. Those patients with critical health care needs, or unstable conditions requiring close medical supervision must be referred to a specific physician competent to handle the case. Verify and document that the patient has been accepted into this physician's practice.

Tip

- A signed authorization for release of medical records—with written notation that the records were released to the physician designated would provide adequate verification and documentation.

Those patients with stable, non-complicated conditions which do not require immediate care can safely be given the general recommendation, in writing, that they place themselves under the care of another physician.

Tip

- Establish a color coded, adhesive dot label system. Red dot to indicate high risk patient. Blue dot for low risk. Categorize current patients during regular office visits. Affix labels to chart cover.

Each active patient must be notified of the physician's termination of medical care. This notification must be in writing. For maximum protection date the letter and send certified mail, return receipt requested. Place a copy of the letter and the signed receipt on the patient's chart.

Note: There is no particular legal connotation to the word "active." It is the prerogative of the individual physician to define it, based upon the nature of the practice.

When possible, provide adequate time for the patient to arrange for alternate medical care. State the date on which you will discontinue medical practice. A reasonable time period can be determined based upon the availability of alternate health care providers in the immediate geographic region.

Tip

- Include Authorization for Release of Medical Information form in the body of your letter. This will reduce copying costs, and eliminate the risk of failing to include enclosure.

Release

Releasing the medical record is an important, yet complicated, task. The medical record, or chart, maintained by a private

Continued on next page

DISPOSITION/Continued

physician in his office is recognized as the property of that physician. The contents of that record, however, are to be made available to the patient (with certain exceptions) or to other treating physicians should either party request them. The Michigan Attorney General in Opinion No. 5125, June, 1978, states the patient "has a right of access and a right to receive copies of information concerning his or her diagnosis or treatment—." Records are to be released within a reasonable period of time. It is permissible to charge a fee for the legitimate costs incurred in assembling, copying and delivering the record.

Retain

Retaining the medical record is imperative to the defense of the physician or (in the event of death) the physician's estate. The record must be accessible and readable. Plaintiff Attorney Paul Hines states, "Not only does the record have to be stored, it has to be in legible condition. A damp or mildewed record could be construed as an incomplete record." There is no law which stipulates the length of time a medical record must be retained and preserved. There is, however, a statute of limitations for the filing of malpractice claims in Michigan. This may be a useful guideline in determining the length of time each physician, or estate, might prudently retain and preserve the record.

Mr. Hines, partner in the law firm, Sommers, Schwartz, Silver & Schwartz, PC, Southfield, explains, "The statute of limitations in Michigan was recently changed." Under the old law (which still applies to claims arising before October 1, 1986) a malpractice claim had to be filed:

- within two years from the date of last treatment, or
- within six months from the date of discovery, or
- within six months from date discovery should have been made.

Claims arising from perinatal and pediatric injuries could be filed up until the child's 19th birthday.

The new law went into effect October 1, 1986, and applies to claims arising since that time. Under this statute the limitation for filing malpractice claims is two years from date malpractice occurred. Claims filed on behalf of children 13 years of age or less must be brought by the child's 15th birthday. Mr. Hines suggests that there may be some inconsistencies in the law, and points out that these have yet to be covered by the standard two year statute of limitation as described above.

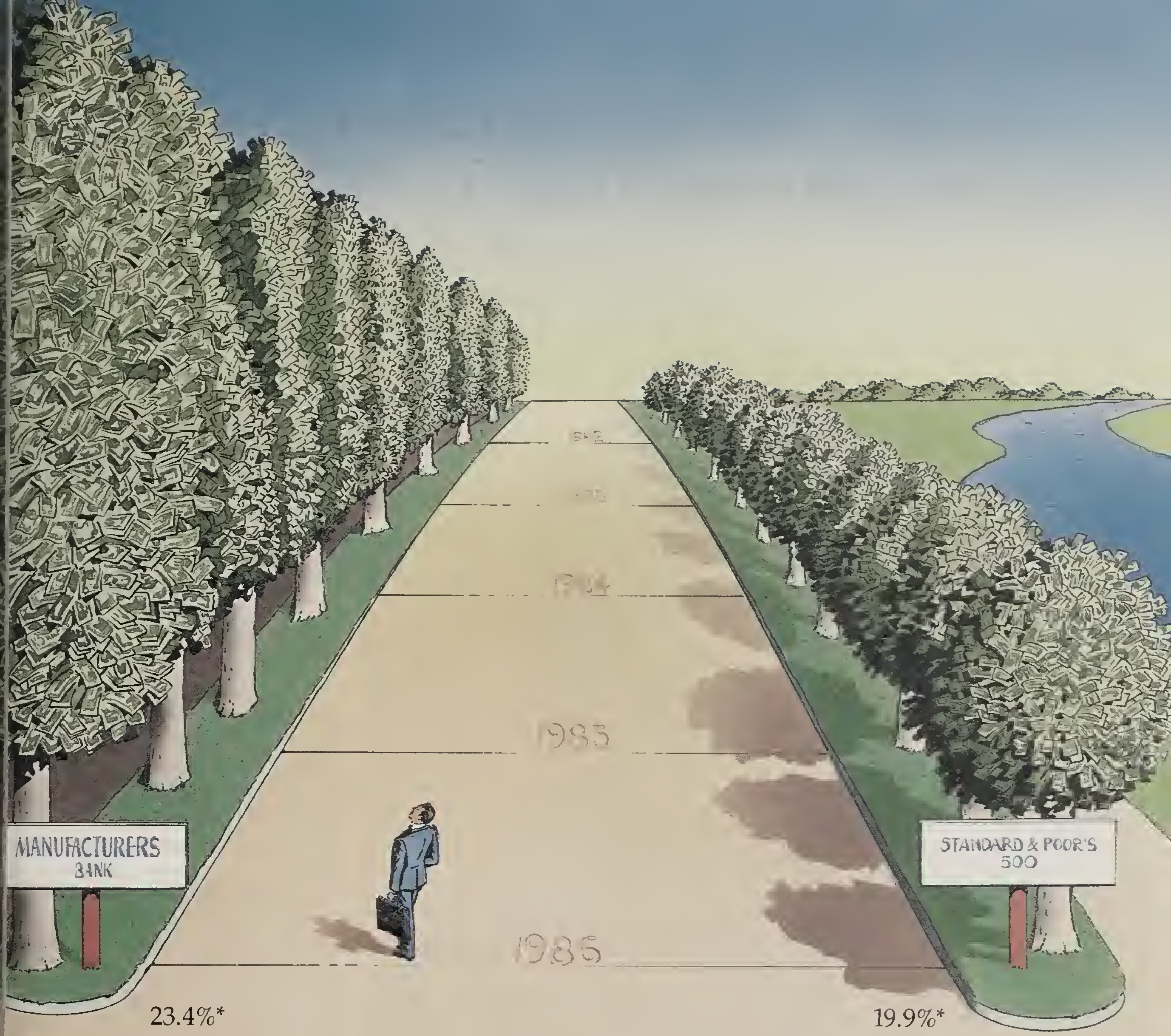
"There is no limitation time on discovery," states Hines. "Discovery means that the claim accrues when all the elements come together: the patient's knowledge of treatment, his knowledge of the injury and his knowledge of the relationship between the two." This variable makes it difficult to determine the length of time the record must be retained.

"As a general rule," says Hines, "this depends upon the nature of the physician's practice. For example, an internist with an adult practice should retain medical records on inactive patients for at least seven years. Obstetricians, pediatricians, those treating the developmentally disabled, including psychiatrists, should retain them longer. The safest course is to maintain them indefinitely."

Jeanne Head, RRA, director of medical records, Harper Hospital, Detroit Medical Center, concurs. "We have medical records as far back as the turn of the century. We have arranged for off-site storage facilities due to the volume." Carole Rausch, ART, assistant director, medical records at the same institution feels in recent years the importance of medical record keeping has increased significantly. "We've been elevated from the cellar to the office next to the CEO."

A survey of physician's offices and large clinics throughout the state support the position of retaining records indefinitely.

Continued on page 248



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Public service a natural extension for advocate/Rep. Teola Hunter

By Carole Eberly

Teola Hunter, the first woman Speaker Pro-Tem of the House, is a dynamo whose days begin at 5:00 am and end at . . .

Being second in line in the House's chain of command behind the Speaker was not in the Detroiter's grand life plan. In fact, politics is fairly new to the former schoolteacher and owner of Buttons and Bows Nursery and Preparatory Schools.

"I had to start at Political Science 101," she said of her first election to the House in 1980. "I wasn't one of these people who came in here from a political background. We have former county commissioners and mayors in the legislature. I had none of that experience."

What she did have was a desire and drive to change day care funding and rules for ADC parents involved in work-training programs. While operating the nursery schools she saw first-hand the need for changes.

"I became an advocate for them," she said. "I came up here and did a lot of lobbying with legislators and was involved in policy-making rules in the Department of Social Services. So that's what eventually got me involved in running for the legislature."

One major change Rep. Hunter (D-Detroit) has noticed in her House tenure is the increase in political activity by physicians. For years, she has known Detroit-area physicians socially. However, it was not until the liability issues came on the scene that she began to see more political action by physicians.

"It has been more so lately and I'm very happy about that," she said.

"For years doctors would not get involved in the political arena," she added. "However, none of us are untouchable with these problems of the world. Now with the liability issue, there is more interaction between the political and medical arenas. This is very much needed."

As chairperson of the Social

The author, Ms. Eberly, is a Lansing-area free-lance writer.

Services and Youth Committee, as well as a member of the Public Health Committee, Rep. Hunter views the issues of AIDS, school-based health clinics and the inability of poor persons to receive medical aid as major areas of health concern. She traces many of Michigan's problems back to poverty.

"We have some major, major problems," she said. "Poverty is one of the major causes of the problems we are having with the foster care system, and with juvenile crime where it's reached epidemic proportions in Detroit.

"How are we going to solve these social problems? Unless we begin to solve these social problems, we cannot begin to say Michigan is a comeback state.

"Industry won't want to come here if we're infested with crime, if it doesn't seem as though we have the answer to curtail or correct what is happening. It all goes hand in hand."

She said an educational and preventative program for AIDS is essential to prevent the alarming spread of the disease, especially in Detroit.

The new school-based health clinics are one way to deal with diseases, teenage pregnancy and drug abuse.

"Many children, contrary to common belief, just do not discuss such personal things with their parents," she said. "Whether it's out of respect or fear, they just don't discuss them."

The ability to reach these students and refer them to the proper professionals is "drastically needed," she said.

> **"We're talking about the working poor whose hospitalization is not subsidized or who cannot afford to go to a doctor. . ."**

She cited the easy accessibility and comfort of having the clinics within the schools as reasons students would choose to use the facilities.

Between the cracks

In the area of the poor and medical aid, Rep. Hunter was concerned about "the people who fall between the cracks."

"We're not talking about the people on welfare or ADC because many of their health care needs are taken care of," she said. "We're talking about the working poor whose hospitalization is not subsidized or who cannot afford to go to a doctor or hospital because of their low wages."

Finding an answer is going to be tough, she admitted.

"Who's going to assume the responsibility?" she asked. "How can you ask a person to get off welfare when they know they have some medical insurance? I wouldn't get off for $3.50 or $4 an hour with no medical coverage. Would you?"

Time off

When not dealing with legislative issues, Rep. Teola would like to be found on downhill ski slopes.

"However, with this winter, I've only been twice," she said.

Her days begin with a two-mile brisk walk—she was a jogger until injuring her knees—and/or a two-mile ride on her stationary bicycle. She finds the exercise necessary to her overall well-being.

"I really miss it when I don't do it," she said.

She would also like more time to spend with her husband and three children, and to spend cooking, which she finds therapeutic.

"I am in my own world when I am in my kitchen," she said. "I can stay in there literally for hours. I enjoy entertaining. I love to eat. I love to cook. I love to have people come into my home and share a meal I have cooked. I find great satisfaction in that."

But, most of all, Rep. Hunter loves her job.

As a teenager she wanted to go into public relations. However, as a young black woman in the 1950s "that was out of the question."

"But now that has become a reality to me," she said. "Because in politics, public relations is one of the main parts of the job."☐

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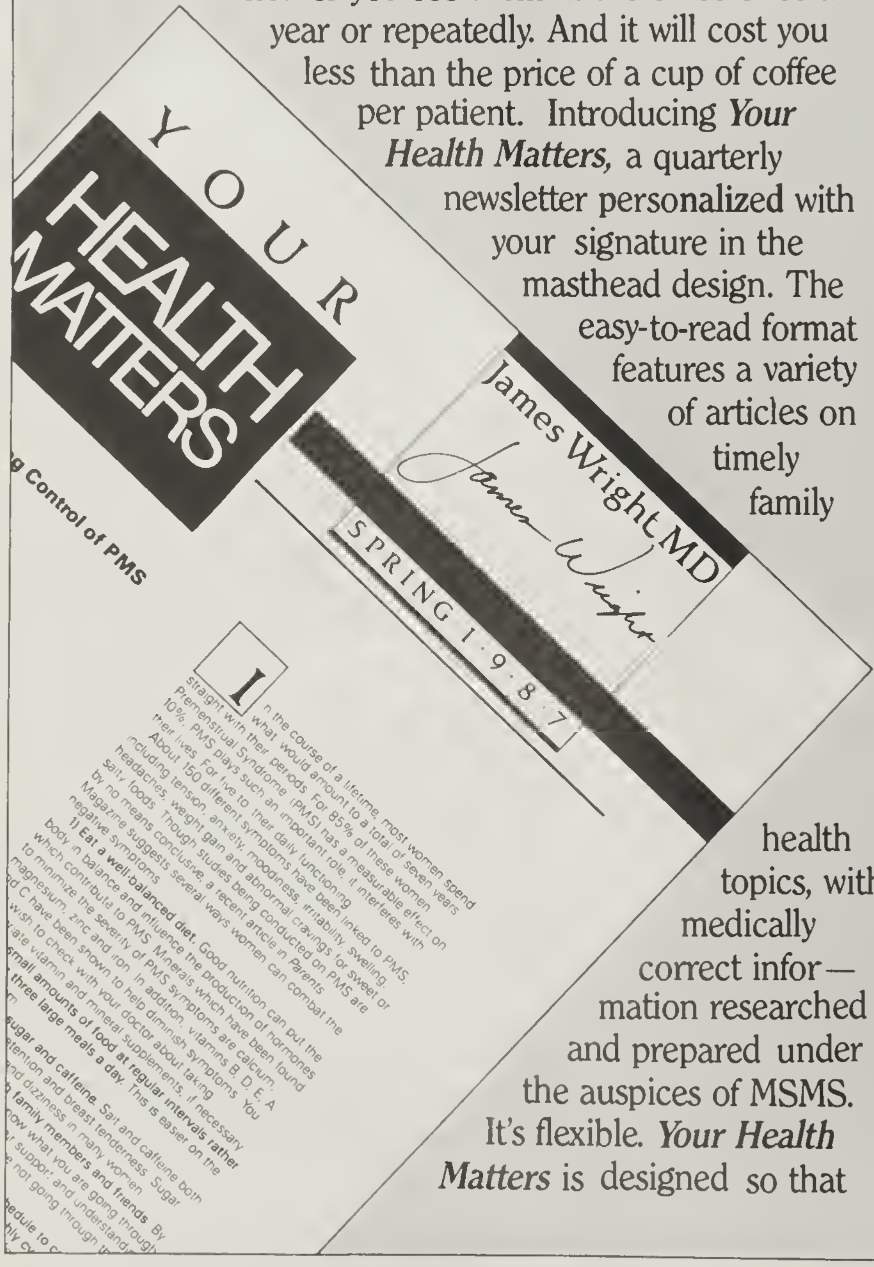

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SPRING 1·9·8·7

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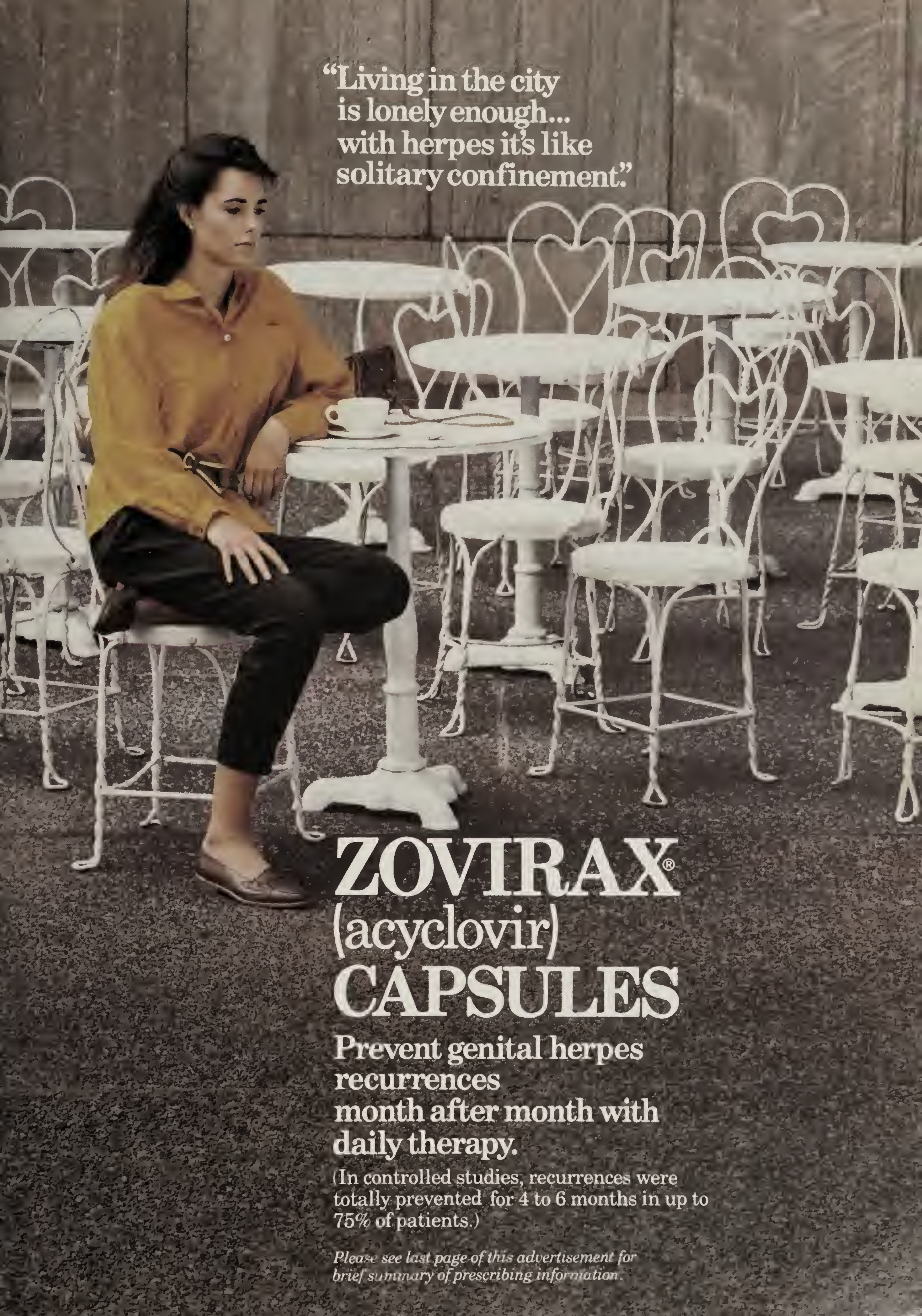
"Living in the city
is lonely enough...
with herpes it's like
solitary confinement."

ZOVIRAX®
(acyclovir)
CAPSULES

Prevent genital herpes recurrences month after month with daily therapy.

(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)

Please see last page of this advertisement for brief summary of prescribing information.

ZOVIRAX®
(acyclovir)
CAPSULES

Help free your patients from recurrences.

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks —month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRA CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/ vomiting, vertigo, and arthralgia.

The physical and emotiona difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episodes as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRAX CAPSULES.

Please see brief summary of prescribing information on next pag

Prevent recurrences month after month*

ZOVIRAX®
(acyclovir)
CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies,. the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤10 ml/min/1.73/m².

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200"- Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

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*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

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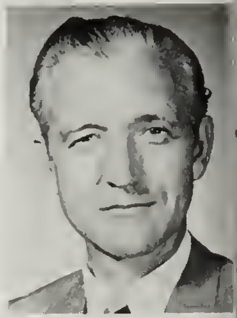
Weaver

Clyde R. Flory, Jr., MD, Lansing, has been elected president of the Ingham County Medical Society. . . . **Robert C. Arends, MD**, Troy, has been elected secretary of the Oakland County Medical Society. . . . **Peter D. VanVliet, MD**, Grand Rapids, has been elected president of the Kent County Medical Society; **Joseph A. Sentkeresty, MD**, Grand Rapids, was named president-elect; and **Ivars Zadvinskis, MD**, Grand Rapids, was elected to a three-year term on the board of directors. . . . **Michael McAuliffe, MD**, Adrian, was appointed to the Bixby Hospital Board of Trustees. . . . **Melvyn Rubenfire, MD**, Detroit, has been appointed by the American College of Cardiology's Board of Trustees to serve on its Board of Governors. . . . **Philip M. Margolis, MD**, Ann Arbor, Professor of Psychiatry and Community Mental Health, University of Michigan Medical Center and School of Public Health, has been elected and installed as President of the Washtenaw County Medical Society. Other elected officers include **Janet K. Baum, MD**, Ann Arbor, president-elect; **Robert Burke, MD, DDS**, Ann Arbor, secretary, and **C. Peter Fischer, MD**, Ypsilanti, treasurer. . . . **Richard A. Stone, MD**, Mt. Clemens, was elected to St. Joseph's Board of Trustees for a three-year term. . . . **Arthur Weaver, MD**, Allen Park, was chosen as one of the “Michiganians of the Year“ by the editors of *Michigan Magazine*. He was chosen for the twenty plus years he devoted to helping people quit smoking. The Breathe Free Stop Smoking Program he designed and personally administers has helped an estimated 100,000 people—the vast majority of them Michiganians—become non-smokers. It has become a model for programs across the country. . . . **Robert A. Teitge, MD**, Warren, had an exhibit displayed by the American Academy of Orthopaedic Surgeons 54th Annual Meeting. The exhibit was entitled “Patellar Subluxation Diagnosed by Stress X-Ray,“ and was displayed in San Francisco's Moscone Center, Civic Auditorium. Upon its return, the exhibit was displayed at Hutzel Hospital, Detroit Medical Center. . . . **Harry N. Herkowitz, MD**, Southfield, has been named president of the Spine Study Group for 1986-87 and is chairman of the course on advanced concepts of diagnosis and treatment of spinal disorders, to be held at Kiawah Island, South Carolina. . . . **Fred Severyn, MD**, Southgate, has been appointed director of professional relations of health care affairs at Blue Cross and Blue Shield of Michigan. . . . **Norman E. Young, MD**, Midland, has been elected president of the Midland County Medical Society. . . . The Muskegon County Medical Society recently chose officers for 1987. They are **Frederick B. Brown, MD**, Muskegon, president; **Robert G. Hylland, MD**, Muskegon, vice president; **W. Richard Harris, MD**, Fruitport, secretary; **Herbert M. Blair, MD**, Muskegon, treasurer. . . . **Kenneth D. McClatchey, MD, DDS**, Ann Arbor, recently assumed a post as a governor of the College of American Pathologists. . . . **John R. Ingall, MD**, Detroit, chairman of the World Federation for Cancer Care, has launched a worldwide program to fight cancer. This program, the International School for Cancer Care, consists of a series of workshops focusing

Continued on page 248

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Goldrath

Shearer

on cancer care, including pain relief and rehabilitation. . . . **Milton H. Goldrath, MD**, Detroit, has developed a laser surgery technique called ablation (removal of the endometrium). This technique is a substitute for hysterectomies in some women suffering from excessive menstrual bleeding. . . . The Mackinac Straits Hospital and the City of St. Ignace have honored **F. Howard Hague, MD**, for his 32 years of service to the community. . . . **S. David Nathanson, MD**, a surgical oncologist at Henry Ford Hospital, Detroit, received a grant for more than $200,000 from the National Institute of Health/National Cancer Institute. . . . Member of the MSMS Board of Directors, **Marguerite Shearer, MD**, Dexter, was installed as chairperson of the Michigan Health Council board. **Terence Davies, MD**, Ann Arbor, was named chairperson-elect of the MHC board. . . . **John M. MacKeigan, MD**, was elected to a four-year term on the board of the American Society of Colon and Rectal Surgeons. ☐

DISPOSITION/Continued

Tip

- Chart extensively. Assume the record will have to stand entirely on its own merit in court.
- Retain all originals.
- Provide storage facilities which will preserve the record.

It is recommended that essential office staff be maintained to handle patient notification of physician termination, release of information requests and accounts receivable. The length of time staff services are retained should be guided by practice needs. Outstanding billing and normal turn-around time for receipt of payments will influence the determination.

If controlled substances are kept in the office notify the Federal Bureau of Narcotics by phone or mail. Controlled substances may be disposed of by returning them to this agency via registered mail, or by destroying the drugs in the presence of a witness and filing DEA form 41:

Federal Bureau of Narcotics
(DEA)
231 West Lafayette, Room 357
Federal Building
Detroit, Michigan 48226
Phone: (313)226-7290

Tip

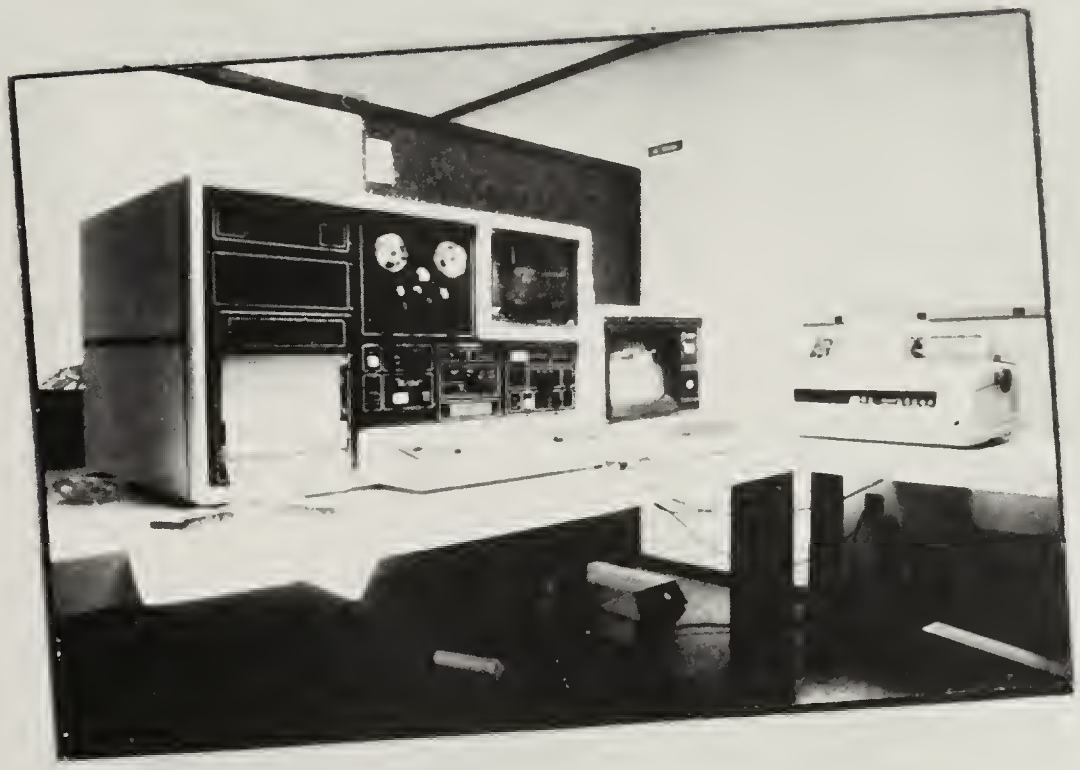
- Obtain and destroy all prescription forms. Remove all physician signature stamps. Dispose of all office pharmaceutical samples. Destroy or return all controlled substances.

Inform:

Michigan Department of
Licensing and Regulation
Board of Medicine
P.O. Box 30018
Lansing, Michigan 48909
Phone: (517)373-0680

Michigan State Medical Society
120 West Saginaw
P.O. Box 950
East Lansing, Michigan
48826-0950
Phone: (517)337-1351

The statements and recommendations herein are general guidelines and are not to be construed as constituting legal advice. ☐



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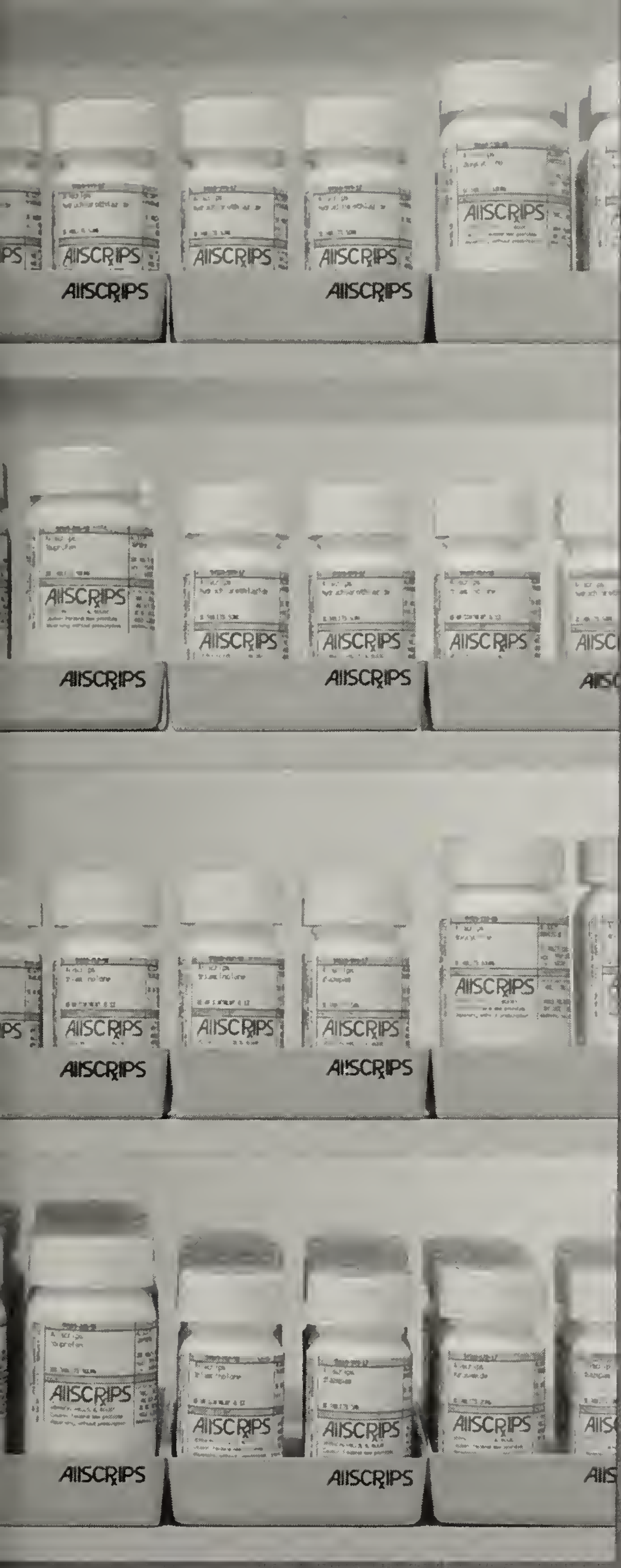

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On dues and other deductions under the IRS code of 1986

By Richard D. Weber, JD

Certain areas of the new tax law will have a direct impact on physicians. These include the deductibility of association dues, business meals and entertainment and professional seminar expenses. Prior to January 1, 1987, these constituted itemized deductions fully available to a physician, whether in private practice or as an employee. The new tax law mandates different results.

> "Physicians can direct the payment of association dues and other professional/educational expenses through their business entity."

Association dues

Dues paid to the AMA, MSMS, component or specialty societies by a physician employee, to the extent not reimbursed by the employer, are treated as "miscellaneous deductions." These dues must be added to other miscellaneous deductions such as other unreimbursed employee business expenses, expenses related to investments, tax preparation fees, etc. The total of all miscellaneous deductions are then deductible only to the extent they exceed two percent of the taxpayer's adjusted gross income.

"You work for I.R.S., eh — so do I."

Meals and entertainment

The deductibility of business meals and entertainment expenses is limited to 80 percent of the actual cost of such expenses. This limitation also applies to meals and entertainment costs incurred while attending educational seminars. The 80 percent portion is further subject to the two percent threshhold mentioned before.

Seminar expenses

Individual deductions for expenses incurred in attending a seminar on personal financial planning are now disallowed. Professional and educational seminars are not covered by this limitation. The direct costs of professional and educational seminars, such as lodging and registration fees, continue to be fully deductible.

Conclusion

To the extent association dues and educational seminar expenses are paid by the employer, they remain fully deductible to the employer. Therefore, physicians who are employees should urge their employer to reimburse them for such expenses. If a physician employee pays the expenses and is not reimbursed, he is subject to the two percent limitation on miscellaneous deductions.

Since most physicians practice in the form of a PC, Partnership or Sole Proprietorship the two percent limitation is inapplicable. A physician can direct the payment of association dues and other professional/educational expenses through their business entity. By deducting these expenses on the business tax return rather than the individual tax return as miscellaneous deductions, the full benefit can be achieved. ☐

The author, Mr. Weber, is MSMS legal counsel with the law firm Kerr, Russell and Weber, Detroit.

Before prescribing, see complete prescribing information in SK&F CO literature or *PDR* The following is a brief summary.

WARNING

This drug is not indicated for initial therapy of edema or hypertension Edema or hypertension requires therapy titrated to the individual If this combination represents the dosage so determined, its use may be more convenient in patient management Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications Concomitant use with other potassium-sparing agents such as spironolactone or amiloride Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia Pre-existing elevated serum potassium Hypersensitivity to either component or other sulfonamide-derived drugs

Warnings **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired** If supplementary potassium is needed, potassium tablets should not be used Hyperkalemia can occur, and has been associated with cardiac irregularities It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency Periodically, serum K⁺ levels should be determined If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake **Associated widened QRS complex or arrhythmia requires prompt additional therapy** Thiazides cross the placental barrier and appear in cord blood Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention Similarly it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide' Do periodic serum electrolyte determinations particularly important in patients vomiting excessively or receiving parenteral fluids and during concurrent use with amphotericin B or corticosteroids corticotropin [ACTH]) Periodic BUN and serum
creatinine deter nations should be made, especially in the elderly,
diabetics or th with suspected or confirmed renal insufficiency
Cumulative effe of the drug may develop in patients with impaired renal
function Thiaz should be used with caution in patients with impaired
hepatic functio ey can precipitate coma in patients with severe liver
disease Obse gularly for possible blood dyscrasias, liver damage,
other idiosyncr reactions Blood dyscrasias have been reported in
patients recei triamterene, and leukopenia, thrombocytopenia,
agranulocytosis d aplastic and hemolytic anemia have been reported
with thiazides azides may cause manifestation of latent diabetes
mellitus The e ts of oral anticoagulants may be decreased when
used concurren with hydrochlorothiazide; dosage adjustments may be
necessary Clin y insignificant reductions in arterial responsiveness
to norepinephrin ve been reported Thiazides have also been shown to
increase the pa ing effect of nondepolarizing muscle relaxants such
as tubocurarine emterene is a weak folic acid antagonist Do periodic
blood studies rhotics with splenomegaly Antihypertensive effects
may be enhan n post-sympathectomy patients. Use cautiously in
surgical patien amterene has been found in renal stones in associa-
tion with the usual calculus components Therefore, 'Dyazide'
should be used caution in patients with histories of stone formation
A few occurrenc t acute renal failure have been reported in patients
on 'Dyazide' w treated with indomethacin Therefore, caution is
advised in adm ering nonsteroidal anti-inflammatory agents with
'Dyazide' The f ing may occur: transient elevated BUN or creatinine
or both, hypergly mia and glycosuria (diabetic insulin requirements may
be altered), hype emia and gout, digitalis intoxication (in hypokalemia),
decreasing alka serve with possible metabolic acidosis. 'Dyazide'
interferes with escent measurement of quinidine Hypokalemia is
uncommon with azide', but should it develop, corrective measures
should be taken as potassium supplementation or increased dietary
intake of potass ich foods Corrective measures should be instituted
cautiously and s n potassium levels determined. Discontinue correc-
tive measures a Dyazide' should laboratory values reveal elevated
serum potassium hloride deficit may occur as well as dilutional
hyponatremia Co rrent use with chlorpropamide may increase the risk
of severe hypona mia. Serum PBI levels may decrease without signs
of thyroid distur ce Calcium excretion is decreased by thiazides
'Dyazide' should withdrawn before conducting tests for parathyroid
function Thiazid may add to or potentiate the action of other anti-
hypertensive drug Diuretics reduce renal clearance of lithium and
increase the risk thium toxicity

Adverse Reactio Muscle cramps, weakness, dizziness, headache,
dry mouth, anaph xis, rash, urticaria, photosensitivity, purpura, other
dermatological co tions; nausea and vomiting, diarrhea, constipation,
other gastrointes al disturbances, postural hypotension (may be
aggravated by alc l, barbiturates, or narcotics). Necrotizing vasculitis,
paresthesias, icte pancreatitis, xanthopsia and respiratory distress
including pneumo s and pulmonary edema, transient blurred vision,
sialadenitis, and v igo have occurred with thiazides alone. Triamterene
has been found in nal stones in association with other usual calculus
components Rare ncidents of acute interstitial nephritis have been
reported Impoten has been reported in a few patients on 'Dyazide',
although a causal ationship has not been established

**Supplied 'Dyazid s supplied as a red and white capsule, in bottles of
1000 capsules, S le Unit Packages (unit-dose) of 100 (intended for
institutional use); in Patient-Pak™ unit-of-use bottles of 100.**

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In concert with diet in non-insulin-dependent diabetes mellitus

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(glipizide) 5-mg and 10-mg Scored Tablets

SYNCHRONIZED SULFONYLUREA THERAPY

Please see brief summary of Glucotrol® (glipizide) prescribing information on next page.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Reference:

1. Sachs R, Frank M, Fishman SK: Overview of clinical experience with glipizide In *Glipizide A Worldwide Review* Princeton, NJ, Excerpta Medica, 1984, pp 163-172

GLUCOTROL® (glipizide) Tablets

Brief Summary of Prescribing Information

INDICATIONS AND USAGE: GLUCOTROL is indicated as an adjunct to diet for the control of hyperglycemia in patients with non-insulin-dependent diabetes mellitus (NIDDM, type II) after an adequate trial of dietary therapy has proved unsatisfactory

CONTRAINDICATIONS: GLUCOTROL is contraindicated in patients with known hypersensitivity to the drug or with diabetic ketoacidosis, with or without coma, which should be treated with insulin

SPECIAL WARNING ON INCREASED RISK OF CARDIOVASCULAR MORTALITY: The administration of oral hypoglycemic drugs has been reported to be associated with increased cardiovascular mortality as compared to treatment with diet alone or diet plus insulin. This warning is based on the study conducted by the University Group Diabetes Program (UGDP), a long-term prospective clinical trial designed to evaluate the effectiveness of glucose-lowering drugs in preventing or delaying vascular complications in patients with non-insulin-dependent diabetes. The study involved 823 patients who were randomly assigned to one of four treatment groups (*Diabetes*, 19, supp. 2:747-830, 1970).

UGDP reported that patients treated for 5 to 8 years with diet plus a fixed dose of tolbutamide (1.5 grams per day) had a rate of cardiovascular mortality approximately 2-1/2 times that of patients treated with diet alone. A significant increase in total mortality was not observed, but the use of tolbutamide was discontinued based on the increase in cardiovascular mortality, thus limiting the opportunity for the study to show an increase in overall mortality. Despite controversy regarding the interpretation of these results, the findings of the UGDP study provide an adequate basis for this warning. The patient should be informed of the potential risks and advantages of GLUCOTROL and of alternative modes of therapy.

Although only one drug in the sulfonylurea class (tolbutamide) was included in this study, it is prudent from a safety standpoint to consider that this warning may also apply to other oral hypoglycemic drugs in this class, in view of their close similarities in mode of action and chemical structure.

PRECAUTIONS: Renal and Hepatic Disease: The metabolism and excretion of GLUCOTROL may be slowed in patients with impaired renal and/or hepatic function Hypoglycemia may be prolonged in such patients should it occur

Hypoglycemia: All sulfonylureas are capable of producing severe hypoglycemia Proper patient selection, dosage, and instructions are important to avoid hypoglycemia Renal or hepatic insufficiency may increase the risk of hypoglycemic reactions. Elderly, debilitated or malnourished patients and those with adrenal or pituitary insufficiency are particularly susceptible to the hypoglycemic action of glucose-lowering drugs Hypoglycemia may be difficult to recognize in the elderly or people taking beta-adrenergic blocking drugs Hypoglycemia is more likely to occur when caloric intake is deficient, after severe or prolonged exercise, when alcohol is ingested, or when more than one glucose-lowering drug is used

Loss of Control of Blood Glucose: A loss of control may occur in diabetic patients exposed to stress such as fever, trauma, infection or surgery It may then be necessary to discontinue GLUCOTROL and administer insulin

Laboratory Tests: Blood and urine glucose should be monitored periodically Measurement of glycosylated hemoglobin may be useful.

Information for Patients: Patients should be informed of the potential risks and advantages of GLUCOTROL, of alternative modes of therapy, as well as the importance of adhering to dietary instructions, of a regular exercise program, and of regular testing of urine and/or blood glucose The risks of hypoglycemia, its symptoms and treatment, and conditions that predispose to its development should be explained to patients and responsible family members Primary and secondary failure should also be explained

Drug Interactions: The hypoglycemic action of sulfonylureas may be potentiated by certain drugs including nonsteroidal anti-inflammatory agents and other drugs that are highly protein bound, salicylates, sulfonamides, chloramphenicol, probenecid, coumarins, monoamine oxidase inhibitors, and beta adrenergic blocking agents. *In vitro* studies indicate that GLUCOTROL binds differently than tolbutamide and does not interact with salicylate or dicumarol. However, caution must be exercised in extrapolating these findings to a clinical situation Certain drugs tend to produce hyperglycemia and may lead to loss of control, including the thiazides and other diuretics, corticosteroids, phenothiazines, thyroid products, estrogens, oral contraceptives, phenytoin, nicotinic acid, sympathomimetics, calcium channel blocking drugs, and isoniazid A potential interaction between oral miconazole and oral hypoglycemic agents leading to severe hypoglycemia has been reported Whether this interaction also occurs with the intravenous, topical, or vaginal preparations of miconazole is not known

Carcinogenesis, Mutagenesis, Impairment of Fertility: A 20-month study in rats and an 18-month study in mice at doses up to 75 times the maximum human dose revealed no evidence of drug-related carcinogenicity Bacterial and *in vivo* mutagenicity tests were uniformly negative Studies in rats of both sexes at doses up to 75 times the human dose showed no effects on fertility

Pregnancy: Pregnancy Category C GLUCOTROL (glipizide) was found to be mildly fetotoxic in rat reproductive studies at all dose levels (5-50 mg/kg). This fetotoxicity has been similarly noted with other sulfonylureas, such as tolbutamide and tolazamide The effect is perinatal and believed to be directly related to the pharmacologic (hypoglycemic) action of GLUCOTROL In studies in rats and rabbits no teratogenic effects were found There are no adequate and well controlled studies in pregnant women GLUCOTROL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Because recent information suggests that abnormal blood glucose levels during pregnancy are associated with a higher incidence of congenital abnormalities, many experts recommend that insulin be used during pregnancy to maintain blood glucose levels as close to normal as possible

Nonteratogenic Effects: Prolonged severe hypoglycemia has been reported in neonates born to mothers who were receiving a sulfonylurea drug at the time of delivery This has been reported more frequently with the use of agents with prolonged half-lives GLUCOTROL should be discontinued at least one month before the expected delivery date

Nursing Mothers: Since some sulfonylurea drugs are known to be excreted in human milk, insulin therapy should be considered if nursing is to be continued

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS: In controlled studies, the frequency of serious adverse reactions reported was very low Of 702 patients, 11 8% reported adverse reactions and in only 1 5% was GLUCOTROL discontinued

Hypoglycemia: See PRECAUTIONS and OVERDOSAGE sections

Gastrointestinal: Gastrointestinal disturbances, the most common, were reported with the following approximate incidence nausea and diarrhea, one in 70, constipation and gastralgia, one in 100 They appear to be dose-related and may disappear on division or reduction of dosage Cholestatic jaundice may occur rarely with sulfonylureas GLUCOTROL should be discontinued if this occurs

Dermatologic: Allergic skin reactions including erythema, morbilliform or maculopapular eruptions, urticaria pruritus, and eczema have been reported in about one in 70 patients These may be transient and may disappear despite continued use of GLUCOTROL, if skin reactions persist, the drug should be discontinued Porphyria cutanea tarda and photosensitivity reactions have been reported with sulfonylureas

Hematologic: Leukopenia, agranulocytosis, thrombocytopenia, hemolytic anemia, aplastic anemia, and pancytopenia have been reported with sulfonylureas

Metabolic: Hepatic porphyria and disulfiram-like alcohol reactions have been reported with sulfonylureas Clinical experience to date has shown that GLUCOTROL has an extremely low incidence of disulfiram-like reactions

Endocrine Reactions: Cases of hyponatremia and the syndrome of inappropriate antidiuretic hormone (SIADH) secretion have been reported with this and other sulfonylureas

Miscellaneous: Dizziness, drowsiness, and headache have been reported in about one in fifty patients treated with GLUCOTROL They are usually transient and seldom require discontinuance of therapy

OVERDOSAGE: Overdosage of sulfonylureas including GLUCOTROL can produce hypoglycemia If hypoglycemic coma is diagnosed or suspected, the patient should be given a rapid intravenous injection of concentrated (50%) glucose solution. This should be followed by a continuous infusion of a more dilute (10%) glucose solution at a rate that will maintain the blood glucose at a level above 100 mg/dL Patients should be closely monitored for a minimum of 24 to 48 hours since hypoglycemia may recur after apparent clinical recovery Clearance of GLUCOTROL from plasma would be prolonged in persons with liver disease Because of the extensive protein binding of GLUCOTROL (glipizide), dialysis is unlikely to be of benefit

DOSAGE AND ADMINISTRATION: There is no fixed dosage regimen for the management of diabetes mellitus with GLUCOTROL, in general, it should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia

Initial Dose: The recommended starting dose is 5 mg before breakfast Geriatric patients or those with liver disease may be started on 2 5 mg Dosage adjustments should ordinarily be in increments of 2 5-5 mg, as determined by blood glucose response. At least several days should elapse between titration steps

Maximum Dose: The maximum recommended total daily dose is 40 mg

Maintenance: Some patients may be effectively controlled on a once-a-day regimen, while others show better response with divided dosing Total daily doses above 15 mg should ordinarily be divided

HOW SUPPLIED: GLUCOTROL is available as white, dye-free, scored diamond-shaped tablets imprinted as follows 5 mg tablet—Pfizer 411 (NDC 5 mg 0049-4110-66) Bottles of 100 10 mg tablet—Pfizer 412 (NDC 10 mg 0049-4120-65) Bottles of 100

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Michigan Medicine continues to be an award winner

Michigan Medicine recently won a Sandoz Special Award for excellence in medical journalism. The following comments were made by Sandoz judge Paul Fisher, professor at the University of Missouri School of Journalism, Columbia:

We are going to give a brief graphic evaluation of the publication Michigan Medicine entered in this year's Sandoz competition and in the state medical journal category. This is a very competitive category, indeed, this year.

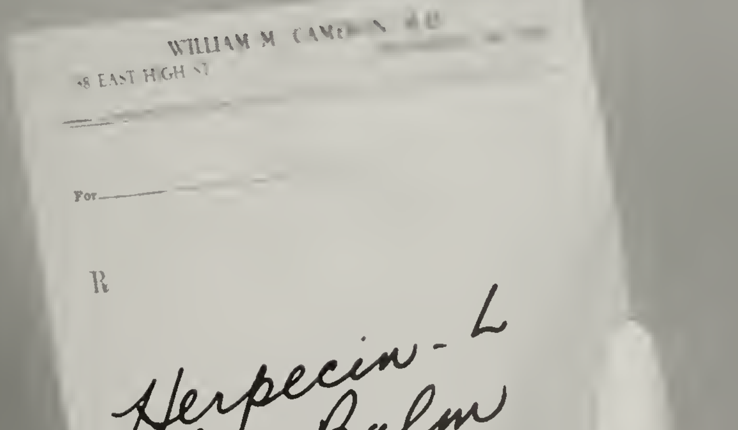
This brief graphic evaluation will be followed in New York by more intensive examination for editorial achievement and certainly *Michigan Medicine* is that. No flattery, it is one of the most extensive of the state journals. It certainly is far ahead of virtually all in turning toward a service orientation and away from the traditional journal. It's always a strong publication, and I believe it's been a winner.

I think the publication has succeeded admirably in making a very firm impression, a very consistent impression for editorial content.

Obviously it goes without saying the magazine is well structured, departments are established and consistent. It is, on top of that, a very disciplined publication, is a very orderly publication, it is really a very sharp publication. I say all of that not in any flattering way either, that is exactly what we have here.

We will be passing this along to the editorial judges in New York, which I am sure will be impressed with the total job being done here. ☐

Dx: recurrent herpes labialis



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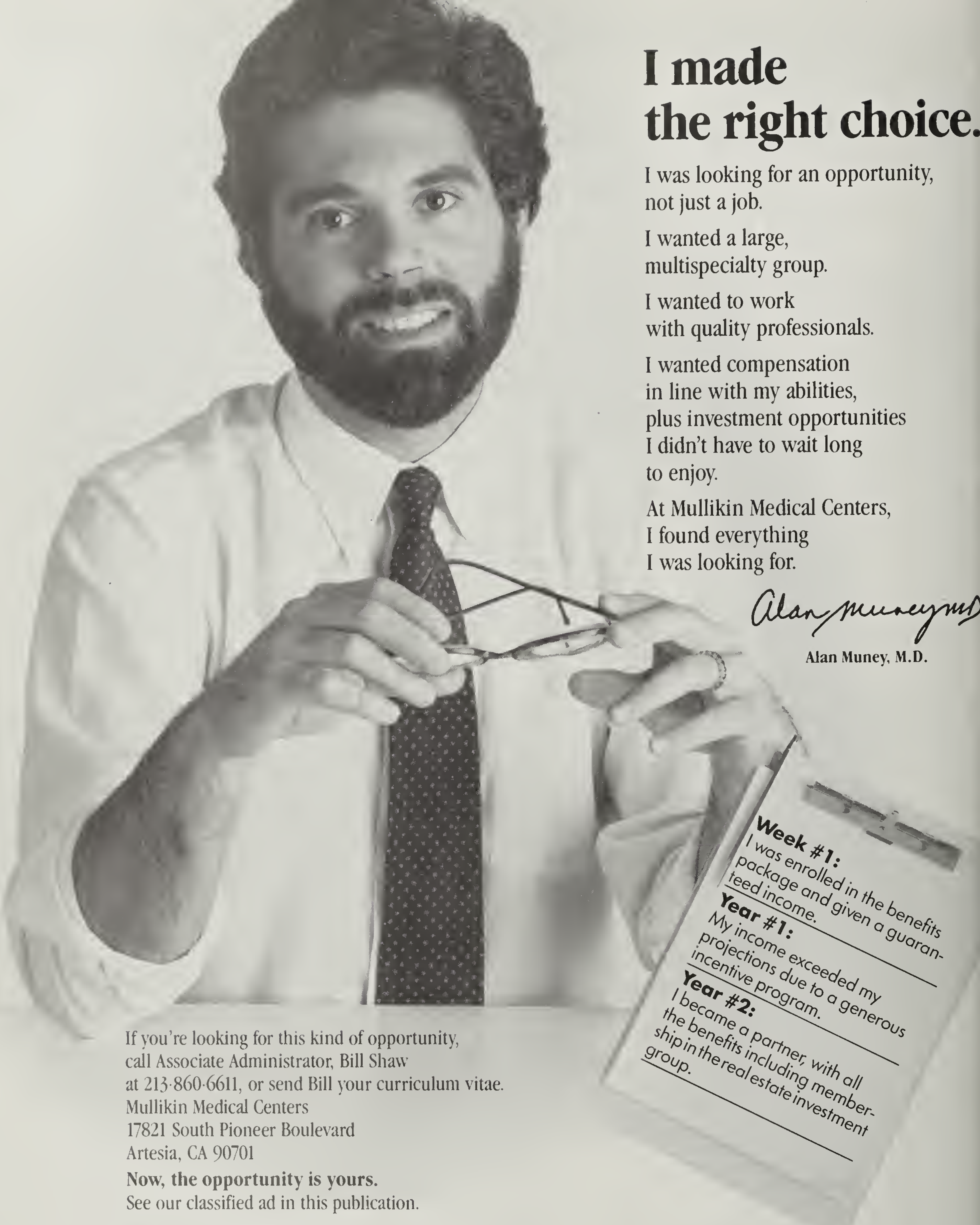

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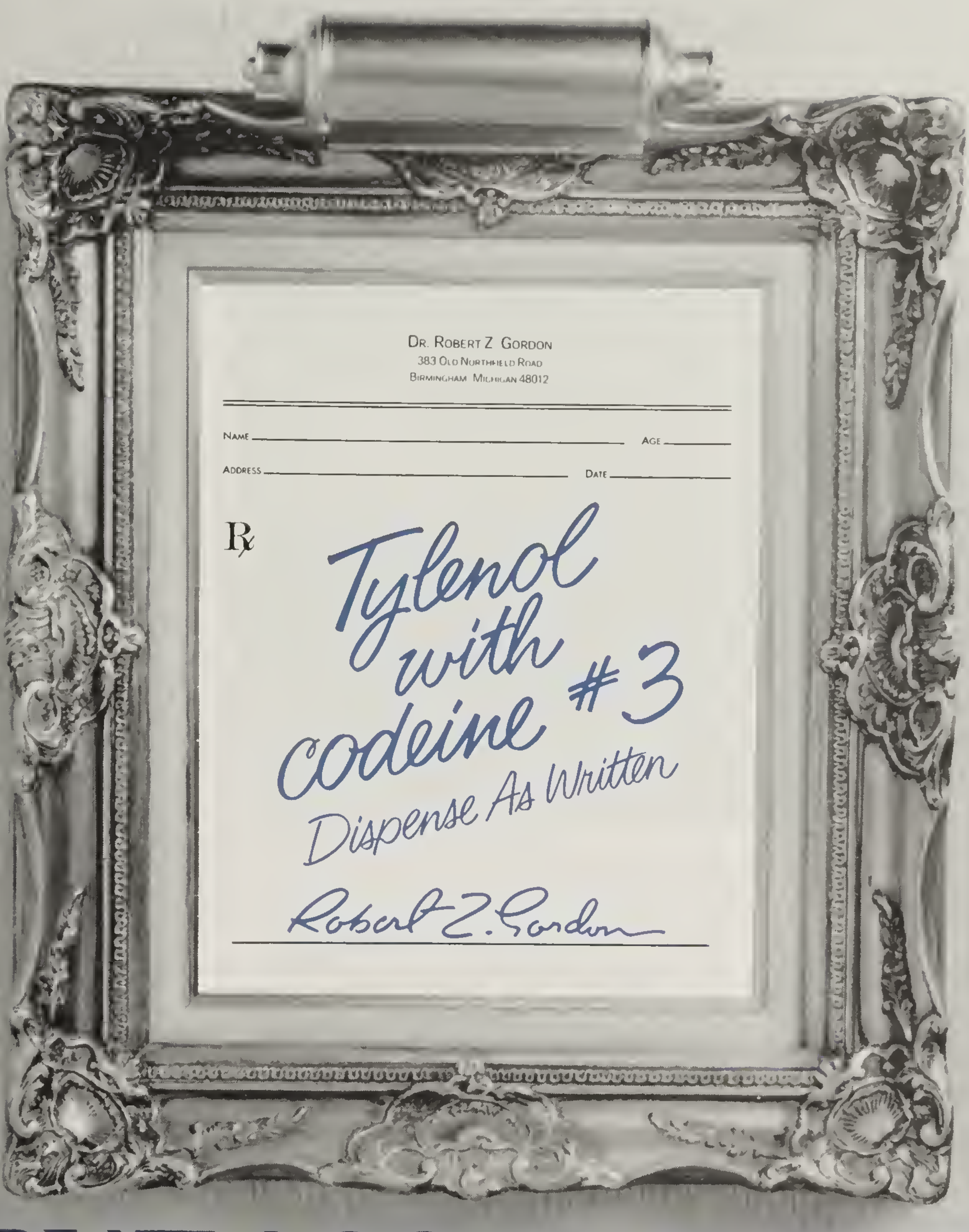

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TYCT 6445-A

Wayne State hosts AMSA regional conference

By Lyle R. Teska

Peter McCabe, MD, discussed malpractice.

It was not a typical Saturday morning at Wayne State. The usually quiet, empty halls of Scott Hall were alive with over 400 medical students who got out of bed unusually early (for a Saturday!) to enjoy breakfast with old friends and new acquaintances. Thus began the 1987 American Medical Student Association (AMSA) Regional Conference held at Wayne State University School of Medicine.

Students from Michigan, Ohio, Indiana, Illinois and Wisconsin assembled February 13-15 to take a break from their studies and explore various issues relevant to them as students and as future physicians.

AMSA is the largest independent organization of medical students in the country. It promotes an awareness of current topics pertaining to medical students and to their future careers, and encourages involvement in school and community projects through its numerous task forces. The Wayne State AMSA chapter accepted the challenge of organizing this year's spring conference and chose as its theme, "Planning Your Future: Residency and Career Development."

The choice of this theme reflected the desire of the conference planners to address the dreaded topic of residency selection. This concern was the topic of the keynote address delivered by Norma Wagoner, PhD, Associate Dean, University of Cincinnati College of Medicine. As one of the foremost experts on residency selection Doctor Wagoner shared results of her research as well as personal insights pertaining to the selection of a residency program. Everyone in attendance appreciated Doctor Wagoner's advice and many felt her talk was the highlight of the conference.

50-member faculty

The remainder of the conference consisted of workshops covering topics ranging from geriatrics to malpractice. Wayne State AMSA members were responsible for recruiting nearly 50 physicians, nurses and other professionals to lead these workshops. In keeping with the theme of the conference, several workshops dealt with further strategies of residency selection including an informal session with senior students who have survived "the match."

One of the most popular series of presentations introduced students to the world of sports medicine. Doctors John Hurley, Robert Burks and David Collon (team surgeon for the Detroit Lions) provided inside stories of sport injuries and advice for students interested in pursuing a career in sports medicine.

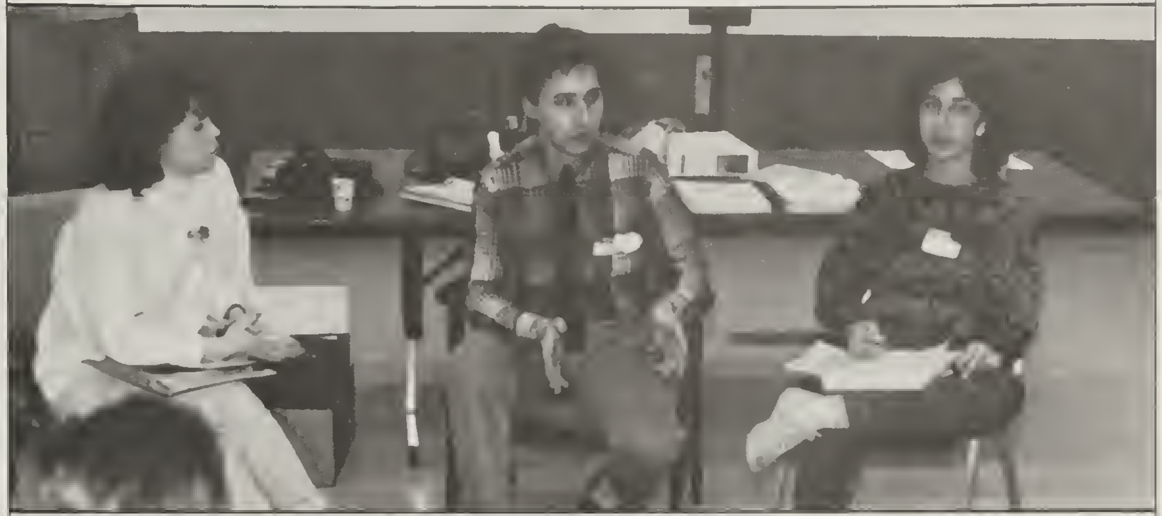
Other workshops dealt with the technically sophisticated side of medical science as well as the harsh reality of third world medicine. Philip Truzhinsky, PhD, head of expert systems at Ford Motor Company introduced participants to medical applications of artificial intelligence while Andrew Zweifler, MD, Amalia

The author, Mr. Teska, is an M-II student, Wayne State University School of Medicine.

McIntyre and Emma Velasquez related their personal experiences with the health care systems of Nicaragua and Guatemala.

Energy and enthusiasm

The AMSA Conference at Wayne State proved to be one of the most successful conferences AMSA members have had the opportunity to attend. The Wayne State AMSA Chapter, under the leadership of president Brian Zehnder, was responsible for providing an educational as well as enjoyable experience. Henry Nadler, MD, Dean of the WSU School of Medicine, noted in his opening address the "energy and enthusiasm" of the AMSA members and referred to the conference as "one of the best continuing education programs" seen in his career.



AMSA officers Jan Frederick, Brian Zehnder and Linda Harris discuss the convention.

According to Linda Harris, AMSA regional trustee, the goal of AMSA conferences is to expose students to outside interests and issues not covered in the traditional medical curriculum. Ms. Harris was personally impressed with the "professionalism" of the WSU Chapter and hopes to use the conference at Wayne State as a national model for future meetings.

Sunday's keynote speaker address was made by Constance Avery-Clark, PhD, Research and Clinical Associate Director of Continuing Education at the Masters and Johnson Institute, who lead a discussion of her research of intimacy in a dual-career relationship.

The conference ended with a regional meeting for delegates representing their schools at the AMSA National Convention to be held in March. Delegates discussed proposals to be examined at the convention including those relating to surrogate mothers, tobacco ads and medical school curriculum.

Scott Hall quickly emptied as students returned to their schools with a new perspective on their chosen career. The conference had come to an end but new issues and concerns surfaced, providing new and exciting material for future conferences. ☐

Conference participants enjoy each other's company at the Valentine's Day Dance held at the Westin Hotel.

Tobacco: the most preventable health problem

A report from the AMA

Tobacco is a dirty
weed. I like it. . .
It satisfies no normal
need. I like it. . .
It makes you thin, it
makes you lean.
It takes the hair right
off your bean.
It's the worst darn stuff
I've ever seen.
I like it.

Graham Lee Hemminger
(1915)

That little message, found in an old anthology of light verse and humorous poetry, very well illustrates the attitude that millions of people had toward smoking until about 20 years ago. But now that tobacco has been indicted and convicted as a killer, the subject isn't amusing any more. It has become deadly serious.

Here are some of the more obvious charges that have been proved:

- Smoking, which has been found more addictive than alcohol or heroin, kills more Americans than any other personal health habit or any other environmental hazard. It was known to be responsible for at least 250,000 deaths a year when the first Surgeon General's Report on Smoking and Health came out in 1964. In 1985, the figure had reached 350,000 per year, based on 1980 mortality figures. According to some experts, the mortality figure is closer to 485,000.
- Nearly one-third of all deaths in the US are caused by addicting substances: five percent from alcohol; two percent from illegal drugs; and 25 percent from tobacco.
- A congressional study reported in 1985 that adverse effects of smoking cost the US an average of $65 billion per year in higher medical bills, premature death and time lost from work. That is $2.17 for every pack of cigarettes consumed—72 cents for health care; $1.45 for lost productivity. (In 1984, about 50 million people in this country still smoked, and about 30 billion packs of cigarettes were sold—that's 600 billion cigarettes.)
- A middle-aged man who smokes two packs a day will incur an average of more than $56,000 in additional cost of illness in his lifetime as a direct result of smoking.
- The American Council on Science and Health added up cases of cigarette-related cancer, heart disease and chronic lung disease since the 1964 report came out. Health care costs, plus loss of productivity because of it, were: for cancer, $242.5 billion; for cardiovascular disease, $373.9 billion; for chronic lung disease, $315.4 billion. Total: $931.8 billion, more than the national debt in 1980 and amounting to $3,959 for every man, woman and child in the US.
- Abundant evidence indicates that a woman's smoking during pregnancy directly retards fetal growth, increases the risk of spontaneous abortion and neonatal death, and leads to deficiencies in growth and development of the child.
- To overcome those facts and keep people smoking, tobacco companies spent $2 billion in 1985 to advertise cigarettes; up from $495.3 million in 1980.

Striking back

Physicians have done a great deal to help lead the fight against the use of tobacco products. And well they should. A 1978 survey of the public showed that respondents ranked physicians' advice as the most effective means of persuading them to quit or reduce smoking. And one of the most important things doctors have done is to set a good example. The 1984 report of the surgeon general on the health consequences of smoking points out that 10 percent of physicians smoke—less than one-third the rate in the general population.

AMA activities

In the past few years, the AMA has taken these steps:

- Declared unequivocal opposition to the use of tobacco products.
- Cooperated with public and private agencies to bring about a

Continued on page 264

Critical judgment

Not all judgments come from courts. Physicians make many critical decisions and now have a choice in medical professional liability insurance: Traditional "occurrence" protection or "claims-made" coverage.

Be judicious. Offshore companies or new insurance entities may offer enticing premiums, but no guarantee of longevity or revenue to cover future costs.

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SMOKING/Continued

tobacco-free society by the year 2000. (Originally, the purpose was stated as a "smoke-free society," but later activities involving smokeless tobacco required the name change.)

- Supported legislation requiring labeling of ingredients added to the tobacco in cigarettes.
- Joined with other groups in favor of an increase in the cigarette tax to 32 cents per pack.
- Urged newspapers and magazines to refuse voluntarily to accept tobacco product advertisements.
- Opposed the availability of low-cost cigarettes on military bases.
- Sought legislation to prohibit smoking on any public transportation and to restrict smoking in public facilities such as restaurants and other buildings.
- Supported legislation for developing a "fire-safe" cigarette.
- Sought legislation to prohibit distribution of tobacco product samples by mail.
- Developed state and local model legislation to prohibit distribution of free cigarette samples on public property.
- Urged stricter rules to limit smoking aboard aircraft.
- Urged all hospitals, offices and other medical care facilities to declare their premises off-limits to smoking.
- Developed printed materials and public service announcements on the hazards of smoking.

Internally, the AMA has prohibited smoking at all of its meetings; has removed cigarette vending machines from its headquarters; and has limited smoking in its headquarters to designated areas. For example, no smoking is permitted in hallways, conference rooms, restrooms or lobbies.

New developments

In the last few years the AMA House of Delegates mounted the strongest anti-tobacco attack in its history.

These are the points made in new policy decisions of the House, each of which was adopted by a large majority of votes:

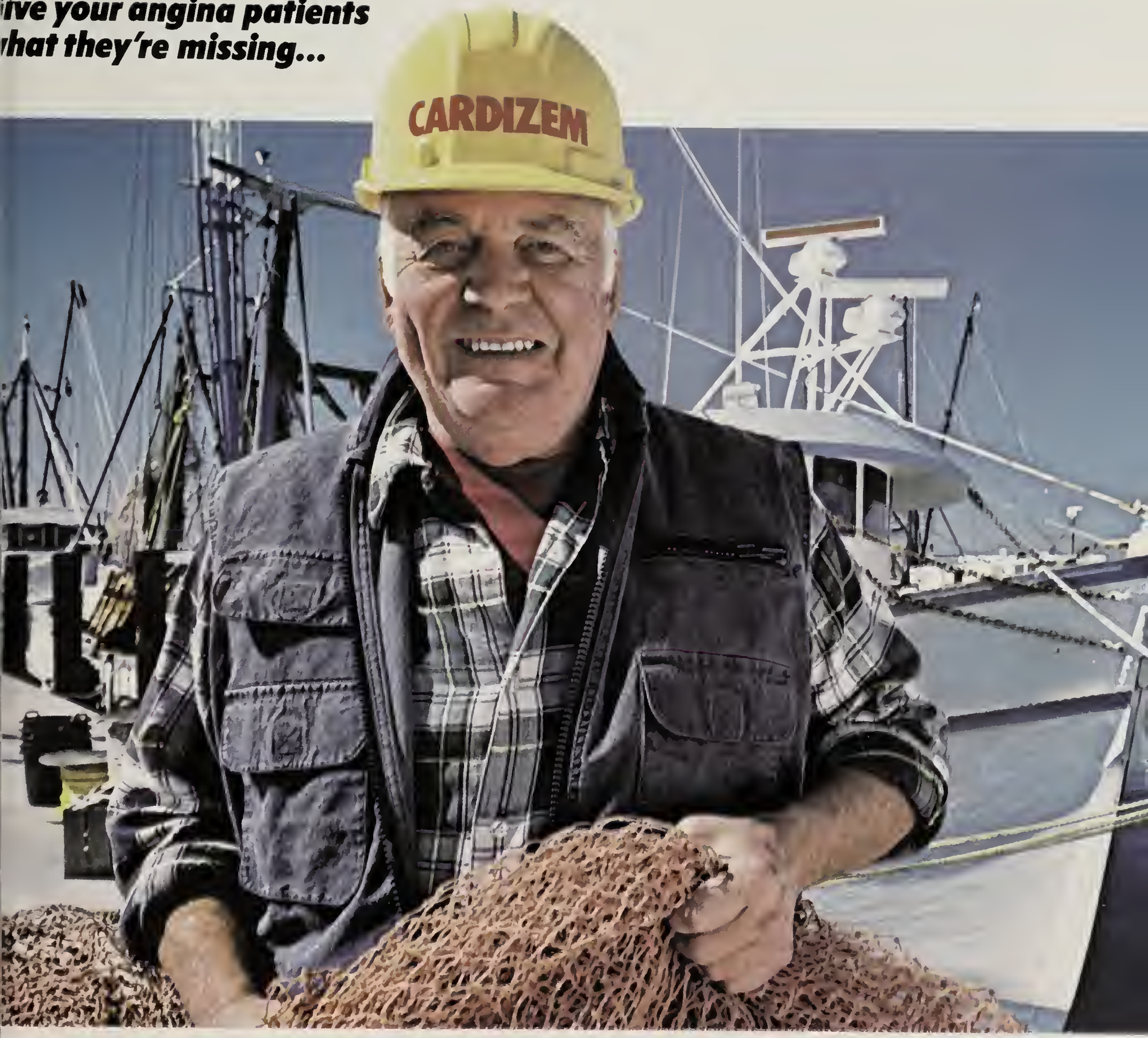
- A ban on all magazine, newspaper and billboard advertising of tobacco products. Right now, only three of the nation's top 20 magazines— *Readers' Digest, Good Housekeeping* and *The Saturday Evening Post*— reject cigarette advertising. Efforts to convince others to do so voluntarily haven't worked. Both the House and Senate recently have introduced legislation that would ban tax deductions for the expense of advertising tobacco products.
- Closer scrutiny of other forms of tobacco promotion such as sponsorship of sporting events, discount coupons and free samples, scholarships, marketing of clothing with cigarette identification, sky writing and arrangements with film companies to display smoking in movies.
- Increased participation by physicians in the tobacco controversy by educating the public about its health hazards and testifying in court about the effects of smoking on an individual's disease.
- Better publicity about the adverse health effects of snuff and chewing tobacco. Although smokeless tobacco is a source of nicotine addiction and oral cancer, the public is relatively unaware of its dangers.
- Encouragement of government authorities to label all smokeless tobacco as a major health hazard; to prohibit its sale to minors; and to ban all advertising of it.

Coincident with the AMA actions, President Reagan signed into law a bill that: 1) prohibits advertising of smokeless tobacco on radio or television and 2) requires three rotating warnings on packages and on all advertisements except billboards. It leaves regulation of billboard advertising for smokeless tobacco to the states.

- Urging the insurance companies to provide financial incentives to nonsmokers, such as premium discounts, reduced deductibles or increased benefits. The same recommendations would apply to PPOs, HMOs and other medical and health care financing systems and delivery organizations.

Continued on page 267

ive your angina patients
hat they're missing...



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- **A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD[4,5]**

***See Warnings and Precautions.**

Please see brief summary of prescribing information on the next page.

CARDIZEM® diltiazem HCl/Marion FEW SIDE EFFECTS IN ANTIANGINAL THERAPY

60 mg tid or qid

Brief Summary
Professional Use Information

CARDIZEM®
(diltiazem HCl) 30 mg and 60 mg Tablets

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. ***Cardiac Conduction.*** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. ***Congestive Heart Failure.*** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*

   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. ***Hypotension.*** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. ***Acute Hepatic Injury.*** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes, however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.*

Pediatric Use. *Safety and effectiveness in children have not been established.*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal:	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic:	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 7/86*

See complete Professional Use Information before prescribing.

References: 1. *Pepine CJ, Feldman RL, Hill JA, et al: Clinical outcome after treatment of rest angina with calcium blockers: Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. Am Heart J 1983, 106(6):1341-1347.* **2.** *Shapiro W: Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. Consultant 1984,24(Dec):150-159.* **3.** *Johnston DL, Lesoway R, Humen DP, et al: Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. Am J Cardiol 1985,55:680-687.* **4.** *Cohn PF, Braunwald E: Chronic ischemic heart disease, in Braunwald E (ed): Heart Disease: A Textbook of Cardiovascular Medicine, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39.* **5.** *Schroeder JS: Calcium and beta blockers in ischemic heart disease: When to use which. Mod Med 1982,50(Sept):94-116.*

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SMOKING/Continued

- Prohibition of the sale of cigarettes through vending machines.

In accordance with the AMA's aggressive anti-tobacco position, the AMA Board of Trustees has approved three new draft federal bills which would:

- Ban the advertising and promotion of tobacco products.
- Authorize the Consumer Products Safety Commission to regulate tobacco products as it does most other consumer products. (Currently, no agency has the authority to hold tobacco products to the safety standards controlling almost all other products.)
- Raise the federal excise tax on cigarettes to 32 cents per package and apportion the revenue from the increases between Part A and Part B of Medicare.

Life expectancy at any age is substantially shortened by cigarette smoking. A 30- to 35-year-old man who smokes two packs a day has a life expectancy eight to nine years shorter than his nonsmoking counterpart.

Smoking will be the primary reason for the deaths of close to half a million people in this country this year, and next year, and every year in which as many people continue to smoke as do now. The major factors in those deaths will be coronary heart disease, lung cancer, chronic obstructive lung disease and other concerns of the respiratory and gastrointestinal tract. ☐

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Research on patient function

The University of Michigan Medical Center has been awarded $148,344 by the Robert Wood Johnson Foundation. The Foundation is funding five demonstration projects and 12 pilot projects totaling $3.5 million aimed at improving medicine's capacity to assist disabled or chronically ill people with their functional abilities.

The U-M project involves the assessment of computerized intervention in cognitively impaired persons.

Prostate cancer study

Catherine McAuley Health Center is coordinating an international study by eight major medical institutions into the reliability of early prostate cancer detection methods.

The National Prostate Cancer Detection Project, as the five-year study is known, calls for annual screening of 5,000 men between the ages of 55 and 70 who show no signs of cancer. The participants will be given a standard urological examination, an ultrasound examination and a prostate antigen assay annually.

The researchers hope to determine whether transrectal ultrasound is more accurate in the early detection of prostate cancer compared to the only currently accepted means, the digital rectal examination. Preliminary research by Fred Lee, MD, a radiologist at Catherine McAuley Health Center, indicates ultrasound is more sensitive in early detection.

The researchers estimate 10 percent of the study group will be found to have prostate cancer using one or the other methods. These men will be referred for treatment.

Conducting a multi-institutional study will help to determine whether the results can be duplicated at other facilities using similar equipment and specially trained technicians. Urologists, radiologists, pathologists and instrument manufacturers will be cooperating in the study.

Lee and Gerald Murphy, MD, a urologist at State University of New York in Buffalo, will serve as co-chairmen of the study.

Reye's Syndrome update

No new cases of Reye's Syndrome have been reported since the last update. Measures of influenza activity in Michigan and the United States indicate a mild influenza season to date. The winter summary will be the next update prepared unless there is specific information to report before then.

Fighting drug and alcohol abuse

Henry Ford Hospital Maplegrove is playing a key role in implementing a comprehensive drug and alcohol abuse awareness and prevention program launched this month by Detroit Edison. The Edison program, which began in Royal Oak this month, takes a "triangle" approach to curbing substance abuse. To be successful in the schools, it must work simultaneously with three groups: teachers, the community (including parents) and students.

The program will be provided in selected school districts throughout the 7,800 square mile Detroit Edison service area, moving next to Southfield and several districts in Macomb County.

It will involve four phases, beginning with a five-day basic workshop for about 200 participants including teachers, administrators and others. The second phase will be a five-evening "Are You Concerned" series coordinated by Maplegrove Community Education, with speakers primarily from the Maplegrove professional staff.

Speakers have reached more than 150,000 in the Dental metropolitan area since the organization began. ☐

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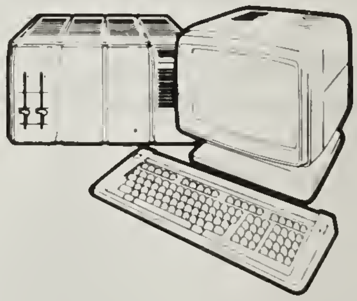

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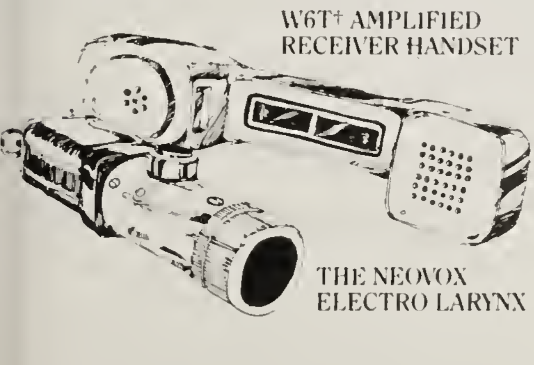

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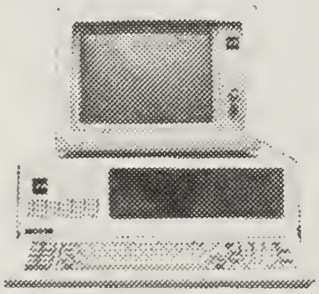

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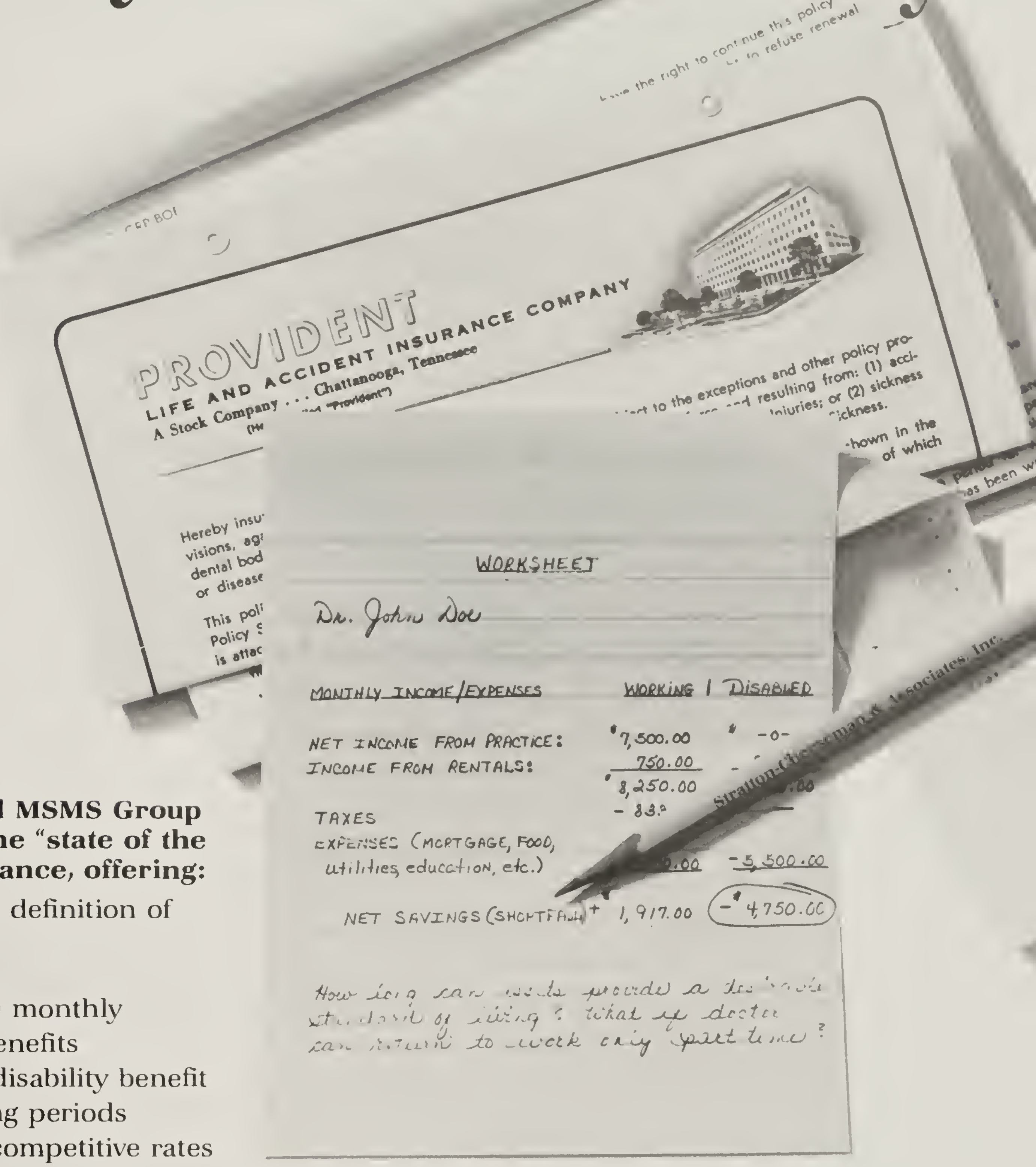
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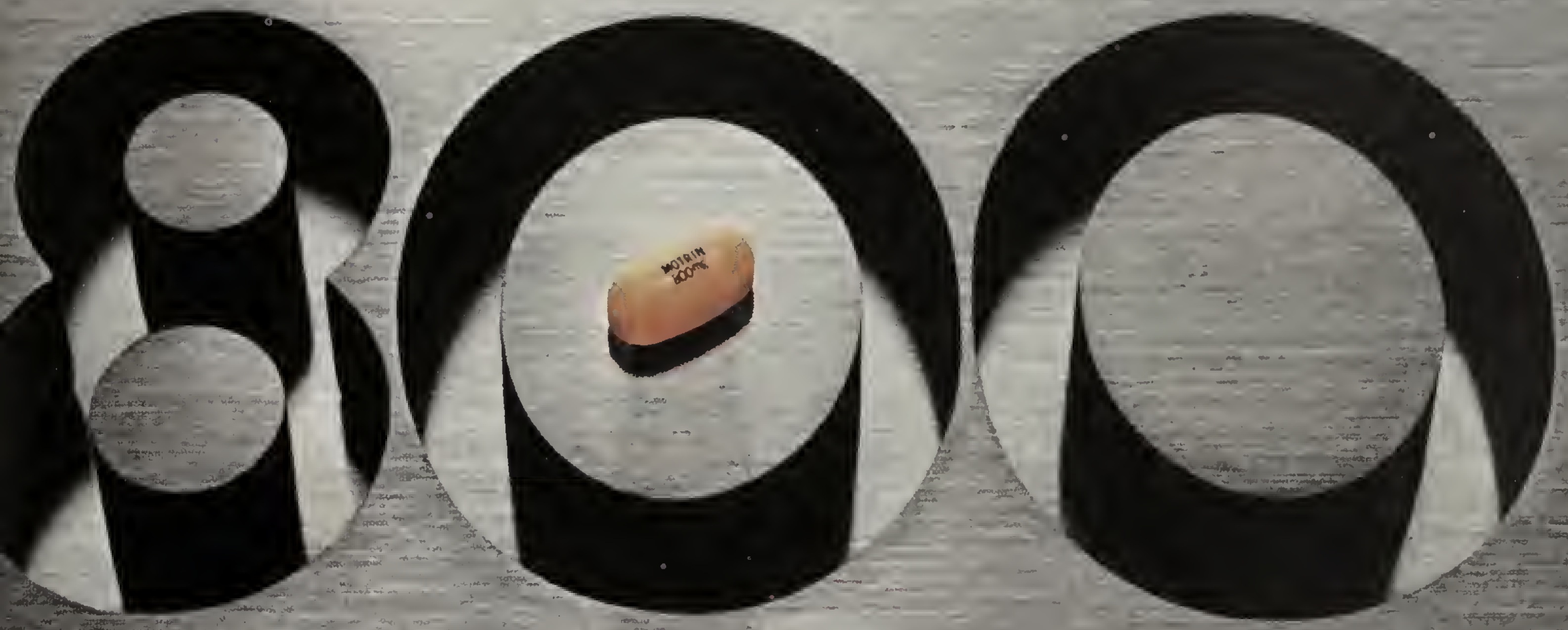

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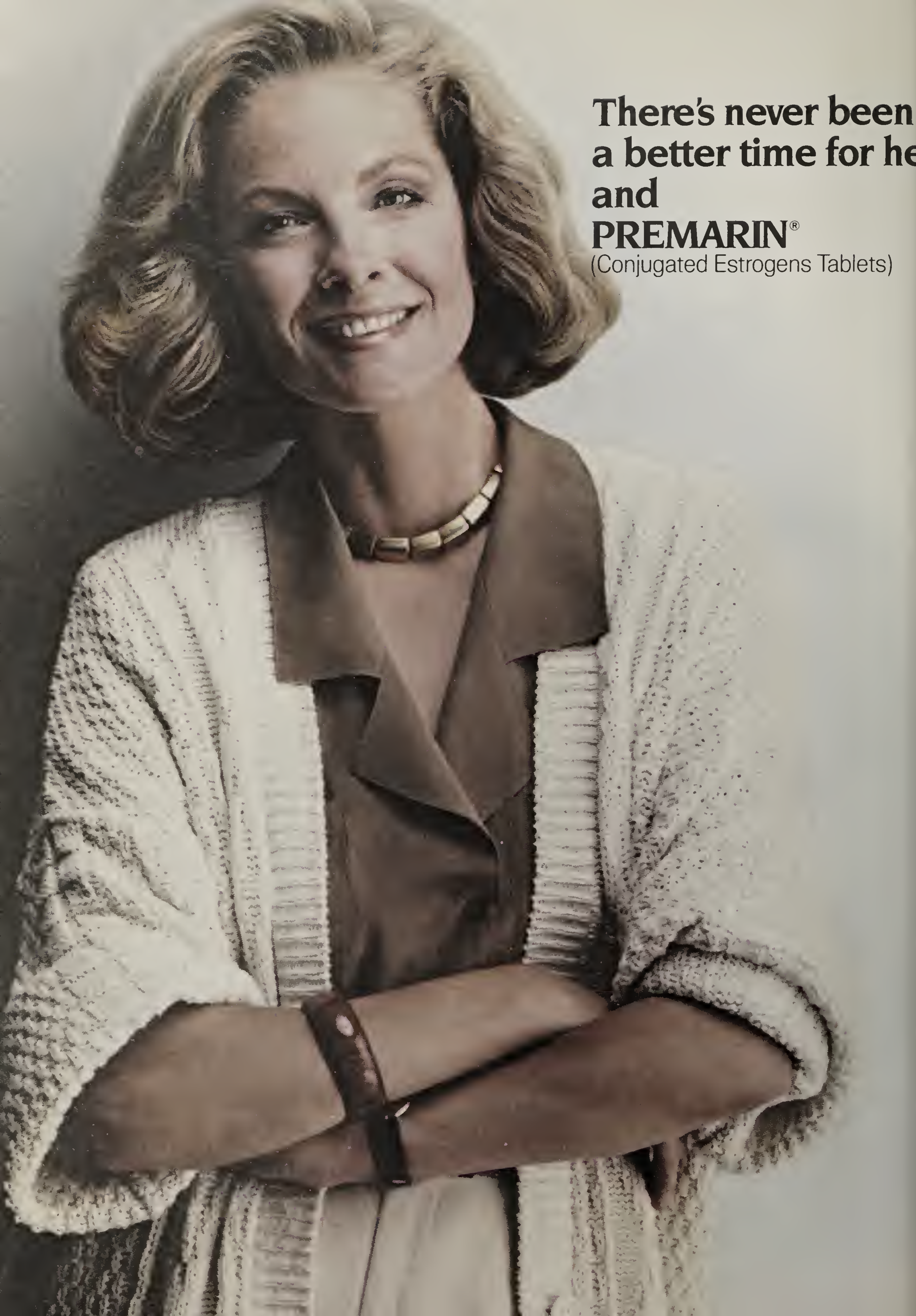
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*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe vasomotor symptoms

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0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

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For atrophic vaginitis

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Vaginal Cream

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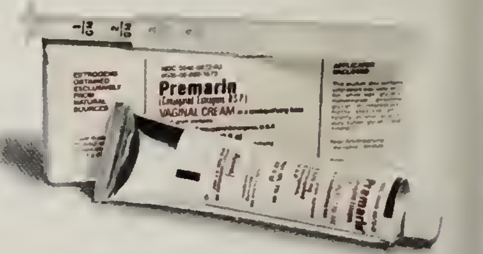

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)*

PREMARIN® Brand of conjugated estrogens tablets, USP
PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

1 ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA.

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13 9 times greater than in nonusers The risk appears to depend on both duration of treatment and on estrogen dose In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix Although these changes are histologically benign, it is not known whether they are precursors of malignancy Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000 In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation

DESCRIPTION: PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine It contains estrone, equilin, and 17α-dihydroequilin, together with smaller amounts of 17α-estradiol, equilenin, and 17α-dihydroequilenin as salts of their sulfate esters Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1 25 mg, and 2 5 mg strengths of conjugated estrogens Cream is available as 0 625 mg conjugated estrogens per gram

INDICATIONS AND USAGE: PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe *vasomotor* symptoms associated with the menopause (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions) **Osteoporosis (abnormally low bone mass)**. Atrophic vaginitis Kraurosis vulvae Female castration

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

Concomitant Progestin Use: The lowest effective dose appropriate for the specific indication should be utilized Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes Whether this will provide protection from endometrial carcinoma has not been clearly established There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens (See PRECAUTIONS) The choice of progestin and dosage may be important, product labeling should be reviewed to minimize possible adverse effects

CONTRAINDICATIONS: Estrogens should not be used in women (or men) with any of the following conditions 1 Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease 2 Known or suspected estrogen-dependent neoplasia 3 Known or suspected pregnancy (See Boxed Warning) 4 Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders 6 A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy)

WARNINGS: Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans (See Boxed Warning) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

PRECAUTIONS: Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use The pathologist should be advised of estrogen therapy when relevant specimens are submitted If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism

The following changes may be expected with larger doses of estrogen:

a Increased sulfobromophthalein retention.

b Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.

c. Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.

d Impaired glucose tolerance

e Decreased pregnanediol excretion.

f. Reduced response to metyrapone test.

g Reduced serum folate concentration.

h. Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk

ADVERSE REACTIONS: The following have been reported with estrogenic therapy, including oral contraceptives breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea; premenstrual-like syndrome, amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria, edema, changes in libido

ACUTE OVERDOSAGE: May cause nausea, and withdrawal bleeding may occur in females.

DOSAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe *vasomotor* symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0 3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals

2 *Given cyclically:* Female castration Osteoporosis. Female castration—1.25 mg daily, cyclically Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis —0.625 mg daily Administration should be cyclic (eg. three weeks on and one week off)

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

References:

1. Whitehead MI, Townsend PT, Pryse-Davies J, et al: Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305 1599-1605 **2.** Paterson MEL, Wade-Evans T, Sturdee DW, et al: Endometrial disease after treatment with oestrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824 **3**. Magos AL, Brincat M, Studd JWW, et al: Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985; 67: 496-499. **4**. Whitehead MI, Lane G, Siddle N, et al: Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women *Semin Reprod Endocrinol* 1983;1:1;41-52. **5.** Barnes RB, Roy S, Lobo RA: Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

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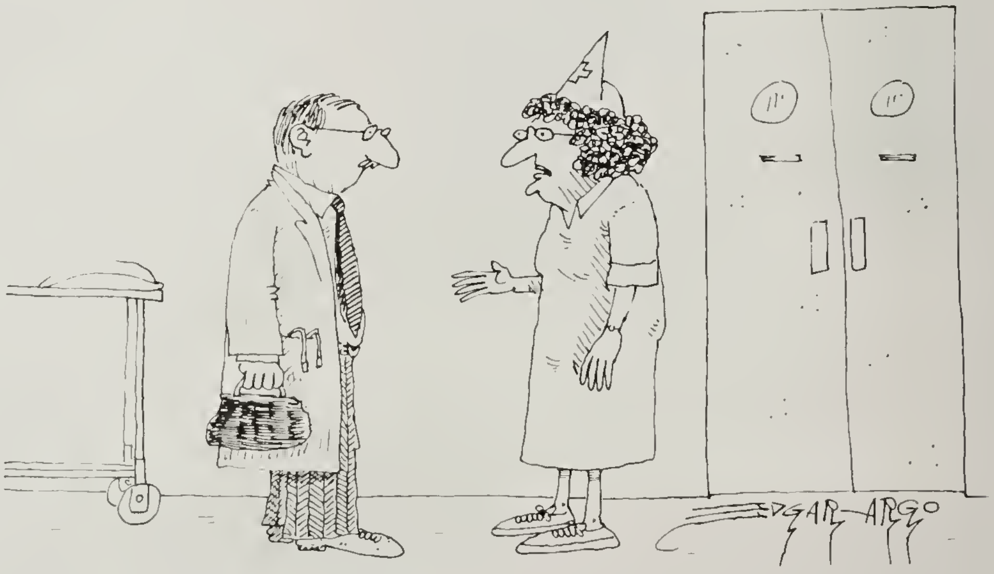

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DEATHS

Thomas E. Andrews, MD
Kalamazoo

Doctor Andrews died February 12, 1987, at the age of 58. He received his bachelors degree in 1951 from Michigan State University and his medical degree in 1955 from the University of Michigan. He served his internship and residency at Blodgett Hospital in Grand Rapids. His primary specialty was general surgery. Doctor Andrews also had served in the US Army from 1957 until 1959.

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Harold W. Carlson, MD
Atlanta, Georgia

Doctor Carlson died December 31, 1986, at the age of 86. He was a 1922 graduate of the University of Minnesota School of Medicine. He served his internship and residency at the Henry Ford Hospital and was a member of the visiting staff during the years of his practice. Doctor Carlson practiced internal medicine in Detroit for 51 years.

Clifford W. Colwell, MD
Flint

Doctor Colwell died January 18, 1987, at the age of 84. He graduated from Detroit City College in 1924 and from the Detroit College of Medicine and Surgery in 1929 (now known as Wayne State University). He was a past president of the Genesee County Medical Society and was the founder of the Flint Academy of Surgery. Doctor Colwell served in the US Air Force from 1942 until 1946.

Wendell R. Doering, MD
Nunica

Doctor Doering died January 16, 1987, at the age of 70. He received his bachelors degree in 1936 and his medical degree in 1940 from Wayne State University Medical School. He served his internship and residency at Providence Hospital. Doctor Doering was an obstetrician and gynecologist and was on the staffs of Mt. Carmel Mercy Hospital and Providence Hospital before his retirement.

Harry C. Matthews, MD
Bay City

Doctor Matthews died November 14, 1986, at the age of 74. He received his medical degree from the University of Michigan in 1937. He was a full time specialist in obstetrics and gynecology, and was affiliated with St. Luke's, Saginaw General and St. Mary's hospitals. Doctor Matthews had served as a Major in the US Army Medical Corps.

Abdul M. Mirza, MD
West Bloomfield

Doctor Mirza died February 5, 1987, at the age of 42. He received his medical degree from the King Edward Medical College in LaHore, West Pakistan in 1966. He served his internship at Mayo Hospital in LaHore from 1967 to 1968. He served an internal medicine intership at the Jewish Hospital in Cincinnati from 1969 to 1970 and served his residency at D.C. General Hospital, Washington, D.C. from 1970 to 1972. Doctor Mirza was an assistant professor at Wayne State University.

Edward L. Moorhead, II, MD
Grand Rapids

Doctor Moorhead died January 30, 1987, at the age of 50. He received his medical degree from Loyola University Medical School in 1962. He served his internship at Mercy Hospital, Loyola University Medical Clinics from 1962 to 1963, and his residency

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- *625 S. Waverly*
- *1322 E. Michigan #102*
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SPORTS MEDICINE

1987 CONFERENCE

Thursday, May 14
Marriott Hotel, Ann Arbor

5 Hours of Category I Credit

Sponsored by the Michigan State Medical Society and
The Michigan Athletic Trainer's Society in cooperation with
Michigan High School Athletic Association.

More people have survived cancer than now live in the City of Los Angeles.

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DEATHS/Continued

in internal medicine at Henry Ford Hospital. In 1986, Doctor Moorhead was recognized by *Good Housekeeping* magazine as one of the top 25 cancer specialists in the nation. He was credited with starting the first community oncology program in the United States. It became a model for similar programs.

John J. Ronayne, MD
Northville

Doctor Ronayne died January 29, 1987, at the age of 66. He received his bachelors degree from St. Michael's College at the University of Toronto. He earned his medical degree from Wayne State University in 1950. He served his internship at Highland Park General Hospital. He was on the staffs of Providence, Highland Park General and Grace hospitals. Doctor Ronayne authored articles pertaining to environmental health.

Edward M. Rotarius, MD
Harper Woods

Doctor Rotarius died February 13, 1987, at the age of 81. He received his medical degree from Wayne State University Medical School in 1930. He was the retired medical director of Parke-Davis and Company. Doctor Rotarius was co-founder and past president of the Industrial Medical Association.

William R. Sargent, MD
Memphis

Doctor Sargent died February 1, 1987, at the age of 75. He received his medical degree from Wayne State University Medical School in 1937. He served his internship and residency at Grace Hospital. He maintained a general practice for almost 50 years.

Ruth M. Waring, MD
Chassell

Doctor Waring died in 1985 at the age of 74. She graduated from Northern Michigan University in 1933 with a BA and received her MD in 1941 from the University of Michigan Medical School. Doctor Waring served her internship and residency at the University Hospital in Ann Arbor. Her specialty was orthopaedic surgery. ☐

MSMS MEETINGS

April

24-25, MSMS House of Delegates, Amway Grand Plaza, Grand Rapids, contact: Richard Campau, MSMS headquarters (517)337-1351.

May

21-22, Committee on Maternal and Perinatal Health, Gull Lake Conference, MSU Gull Lake Conference Center, contact: Katie Brewbaker, MSMS headquarters (517)337-1351.

June

14-19, School Worksite Wellness, MSMS, Michigan Health Council and others, Mackinac Island, contact: Debbie Zannoth, MSMS headquarters (517)337-1351.

17, Effective Writing, a workshop for county medical society editors, executive directors, medical writers and journalism students, Radisson Hotel, Lansing, contact: Judy Marr or Sherry Wellman, MSMS headquarters (517)337-1351.

July

16-19, MSMS Board of Directors Midsummer Meeting, Deer Lake, Boyne Mountain, contact: William Madigan (517)337-1351.

September

23, MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

October

14, County Medical Society Executives Meeting, MSMS headquarters, East Lansing, contact Wayne Burmeister, MSMS headquarters (517)337-1351.

21, 1987 Public Affairs Leadership Conference, Clarion Hotel and Conference Center, Lansing, contact: Sherry Wellman, MSMS headquarters (517)337-1351.

November

18, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

AMA MEETINGS

April

20-22, AIDS and Public Policy: A Community Response, Chicago Marriott Hotel, Chicago, contact: Pat Clark, AMA (312)645-4497.

25-26, DNA Probes in the Practice of Medicine, Hyatt Regency Hotel/Capitol Hill, Washington, DC, contact: Bill Silberg, AMA (312)645-4417.

MSMS/A, AMA/A

May

4-6, MSMS Auxiliary Annual Meeting, Holiday Inn, Petoskey, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

MICHIGAN SPECIALTY SOCIETY MEETINGS

April

15, Michigan Allergy Society Meeting, Children's Hospital of Michigan, contact: Viola M. Heins, MSMS headquarters (517)337-1351).

23-26, MSMA Annual Convention, Sheraton Inn, Lansing, contact: Cathy Cater, CMA, 1327 E. Michigan, Lansing 48912 (517)485-2130.

30-5/1, Michigan Chapter, American College of Surgeons, Annual Coller Day Competition and Scientific Meeting, Amway Grand Plaza, Grand Rapids, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

May

1, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

15-17, Michigan Association of Medical Education Annual Meeting, Holiday Inn, Petoskey, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

16-17, Michigan Society of Pathologists Annual Meeting, St. Clair Inn, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

19-22, Michigan Society of Respiratory Care, Flint Hyatt Regency, contact: Caroline Rich, MSMS headquarters (517)337-1351.

20, Michigan Allergy Society Meeting, University of Michigan, Ann Arbor, contact: Viola M. Heins, MSMS headquarters (517)337-1351.

Continued on next page

MI SPECIALTIES/Continued

June

5, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

25-28, Michigan Otolaryngological Society, Summer Scientific Meeting, The Homestead, Glen Arbor, contact: Karen Turner, executive secretary (313)567-1640.

July

10, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

10-11, Michigan Society of Thoracic Surgeons Annual Meeting, Grand Traverse Resort Village, Traverse City, contact: Rodman E. Taber, MD, secretary (313)567-1640.

10-12, Michigan Dermatological Society, Grand Traverse Resort Village, Traverse City, contact: Debbie Samalis, executive secretary (313)554-1891.

August

15-16, Michigan Academy of Family Physicians Congress of Delegates, Grand Traverse Resort Village, Traverse City, contact: Janice Klos, chief executive officer (517)482-7410.

17-19, Michigan Academy of Family Physicians Annual Meeting, Grand Traverse Resort Village, Traverse City, contact: Janice Klos, chief executive officer (517)482-7410.

18-21, Michigan Health Officers Association, Annual General Membership Meeting, Grand Traverse Resort Village, Traverse City, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144. ☐

19-20, Michigan Society of Thoracic Surgeons Meeting, Grand Hotel, Mackinac Island, contact: Rodman E. Taber, MD, secretary (313) 567-1640.

NATIONAL SPECIALTY SOCIETIES

May

3-7, American Association of Neurological Surgeons Annual Meeting, Dallas, contact: Carl H. Hauber, Executive Director, 22 S. Washington, Suite 100, Park Ridge, IL 60068 (312)692-9500.

9-14, American Academy of Pediatrics Annual Meeting, San Francisco, contact: James E. Strain, MD, Executive Director, 141 Northwest Point Road, P.O. Box 927, Elk Grove Village, IL 60007 (312)288-5005.

10-13, American Lung Association and American Thoracic Society Annual Meeting, New Orleans, contact: S. R. Iannotta, Executive Director, 1740 Broadway, New York, NY 10019 (212)315-8778.

17-21, American Urological Association Annual Meeting, Anaheim, contact: Richard J. Hannigan, Executive Secretary, 1120 N. Charles St., Baltimore, MD 21201 (301)727-1100.

June

2-5, Society of Nuclear Medicine Annual Meeting, Toronto, contact: Henry L. Ernstthal, Executive Director, 136 Madison Avenue, New York, NY 10016 (212)889-0717.

21-26, College of American Pathologists, American Society of Clinical Pathologists Annual Meeting, Washington, DC, contact: Robert A. Dietrich, MD, 2100 W. Harrison Street, Chicago, IL 60612 (312)738-1336.

September

14-17, American Academy of Family Physicians Annual Meeting, San Francisco, contact: Robert Graham, MD, 1740 W. 92nd Street, Kansas City, MO 64114.

OTHER MEETINGS

May

4-5, Michigan Association for Infant Mental Health 11th Annual Conference—Infants and Families in Poverty, University of Michigan, contact: U-M Extension Service, Conferences and Institutes, 200 Hill Street, Ann Arbor 48104 (313)764-5304.

7, Michigan Radiological Society Annual Meeting, 1010 Antietam, Detroit, contact: Dianne Hansen, administrative secretary, 1010 Antietam, Detroit 48207, (313) 567-1640.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medi-ine to obtain Category 1 credit toward meeting the requirements of Michigan law. Sponsors of Category 1 programs and courses in Michigan are invited to submit information for the monthly alendar.

Each listing below, of programs that carry at least 3 hours of Category 1 credit, indicates a con-act person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

April

26, Neurology. **Location:** Mt. Pleasant Holiday Inn, Mt. Pleasant. **Sponsor:** Central Michigan Community Hospital, Mt. Pleasant. **Contact:** Mary Jane Post, CMCH Staff Coordinator, Mt. Pleasant 48858 (517)772-6727. **Approved for:** 7 hours of Category 1 Credit.

26, Laboratory Session: Techniques of ECMO. **Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Departments of Surgery and Pediatrics and Communicable Diseases. **Contact:** Janet Boomer, Towsley Center for Continuing Medical Education, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 8 hours of ACCME Category 1 Credit.

27, EMCO Seminar: Extracorporeal Membrane Oxygenation for Neonatal Respiratory Failure. **Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Departments of Surgery and Pediatrics and Communicable Diseases. **Contact:** Janet Boomer, Towsley Center for Continuing Medical Education, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 11.25 hours of Category 1 Credit.

27, Suicidal Behavior and the Chosen Method of Suicide. **Location:** Ann Arbor. **Sponsor:** The Extension Division of The Michigan Psychoanalytic Institute. **Contact:** Michigan Psychoanalytic Institute, 16310 W. Twelve Mile Road, Suite 204, Southfield 48076 (313)559-5855. **Approved for:** 15 hours of Category 1 Credit.

28, 12th Annual Infectious Diseases Symposium. **Location:** Marriott Hotel, 5700 28th Street, SE, Grand Rapids. **Sponsor:** Butterworth Hospital. **Contact:** Celia M. Steele, Conference Coordinator, Butterworth Hospital, 100 Michigan Northeast, Grand Rapids 49503 (616)774-1774. **Approved for:** 6 hours of Category 1 Credit.

29, A Seminar on Advanced Topics: Neonatal ECMO. **Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Surgery and Pediatrics and Communicable Diseases. **Contact:** Janet Boomer, Towsley Center for Continuing Medical Education, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 10 hours of Category 1 Credit.

30, Mind, Brain and Body. **Location:** Campus Inn, Ann Arbor. **Sponsor:** The Michigan Psychiatric Society. **Contact:** Sarah Allison, Executive Director, Michigan Psychiatric Society, 21700 Northwestern Highway, Suite 1150, Southfield 48075 (313)552-8666. **Approved for:** 6 hours of Category 1 Credit.

May

1, 11th Annual Preventive Cardiovascular Medicine and Rehabilitation Symposium. **Location:** John E. Fetzer Business Development Center—Kirsch Auditorium, Western Michigan University, Kalamazoo. **Sponsor:** Borgess Medical Center—Institute for Cardiovascular Health, Southwestern Michigan Area Health Education Center, American College of Sports Medicine and American Heart Association. **Contact:** Jeff Morgan, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 5 hours of Category 1 Credit.

7-9, Medicolegal Investigation of Death. **Location:** Hotel Pontchartrain, Detroit. **Sponsor:** Wayne State University School of Medicine Department of Pathology, Wayne County Medical Examiner's Office, with the cooperation of the Criminal Defense Attorneys of Michigan. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4-H University Health Center, 4201 St. Antoine, Detroit 48201 (313)577-1180. **Approved for:** 15.5 hours of Category 1 Credit.

9, Microsurgical Solutions to Reconstructive Problems in the Extremities. **Location:** The Westin Hotel O'Hare, Chicago. **Sponsor:** The American Society For Surgery of the Hand in cooperation with the American Society for Reconstructive Microsurgery. **Contact:** American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, Colorado 80014 (303)755-4588.**Approved for:** 8 hours of Category 1 Credit.

11-15, 15th Annual Spring Update, Advances in Internal Medicine. **Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Department of Internal Medicine, Ann Arbor. **Contact:** Georgia Barton, Office of Continuing Medical Education, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 33.5 hours of Category 1 Credit.

14, Sports Medicine/MATS Conference. **Location** Marriott Inn, Ann Arbor. **Sponsor:** Michigan State Medical Society and Michigan Athletic Trainers Society, in cooperation with Michigan High School Athletic Association. **Contact:** Sherry L. Fent, MSMS, 120 W. Saginaw, East Lansing 48826-0950 (517)337-1351. **Approved for:** 6 hours of Category 1 Credit.

14, Sexually Transmitted Diseases—1987. **Location:** Fetzer Business Development Center, Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **Contact:** Charles L. Zeller, Jr., MD, Southwestern Michigan Area Health Education Center, 4th Floor, Stryker Center, 1521 Gull Road, Kalamazoo 49001. **Approved for:** 6 hours of Category 1 Credit.

14, Perinatal Periscope—A Look to the Future. **Location:** Bernhard Student Center, Western Michiagn University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association, Southwestern Michigan Area Health Education Center and the American Academy of Family Physicians. **Contact:** Wendy Finsterwald, Southwestern Michigan Perinatal Association, 252 East Lovell Street, Kalamazoo 49007 (616)383-4669. **Approved for:** 6 hours of Category 1 Credit.

15-17, Advanced Cardiac Life Support (Provider & Recertification) Course. **Location:** Gilmore Center of Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Life Support Services and

Continued on next page

CATEGORY I/May continued

Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. **Approved for:** Category I Credit: 20 credits for ACLS and 6 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

15-17, The Differential Diagnosis of Musculoskeletal Pain: Emphasis on the Low Back. **Location:** Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU College of Osteopathic Medicine, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 20 hours of Category I Credit.

16-17, A Practical Approach for Differential Diagnosis of Diseases of Lymph Nodes, Genito-Urinary Pathology—New Developments in Diagnostic Techniques, Risk Management. **Location:** St. Clair Inn. **Sponsor:** Michigan Society of Pathologists. **Contact:** Viola M. Heins, MSMS, 120 W. Saginaw, East Lansing, 48826-0950 (517)337-1351. **Approved for:** 7 hours of Category I Credit.

20, Current Update in the Treatment of Breast Carcinoma. **Location:** Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital Continuing Medical Education Committee. **Contact:** Carol Mastroianni, Program Coordinator, CME, Saint John Hospital, 22101 Moross Road, Detroit 48236 (313)343-3877. **Approved for:** 7 hours of Category I Credit.

27-31, Tutorial on Level II Manual Medicine Techniques (Below Diaphragm). **Location:** Kellogg Center for Continuing Education, MSU. **Sponsor:** MSU College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, MSU College of Osteopathic Medicine, A306 E. Fee Hall, East Lansing 48824 (517)353-9714. **Approved for:** 40 hours of Category I Credit.

June

3, Current Topics in Blood Banking: 14th Annual Symposium, Pre-Conference Workshop. **Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201. **Sponsor:** The University of Michigan Medical School, Department of Pathology. **Contact:** Gayle Fox, Office of Continuing Medical Education, Towsley Center—Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 4 hours of Category I Credit.

4-5, 13th Annual Kalamazoo Symposium for Michigan Neonatologists and Neonatal Fellows. **Location:** Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Neonatology Services of the Pediatric Section, Bronson Methodist Hospital and Mead Johnson Laboratories. **Contact:** John V. Hartline, MD, Neonatology Services of the Pediatric Section, Bronson Methodist Hospital, 252 East Lovell, Kalamazoo 49007. **Approved for:** 7.25 hours of Category I Credit.

4-5, Current Topics In Blood Banking: 14th Annual Symposium. **Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor 48109-0201. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Gayle Fox, Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 12 hours of Category I Credit.

11-12, A Healthy Future for Michigan's Mothers and Babies. **Location:** Clarion Hotel, Lansing. **Sponsor:** Michigan Healthy Mothers/Healthy Babies Coalition, and Detroit Wayne County Infant Health Promotion Coalition, the Greater Detroit Area Health Council, Inc., March of Dimes, Michigan Department of Public Health, Michigan Public Health Association, and New Detroit, Inc.. **Contact:** Terry Wright (313)876-4667 or Pamela Walsh (313)963-4990. **Approved for:** 10.5 hours of Category I Credit.

12-14, Urology Outing. **Location:** Grand Traverse Resort, Traverse City. **Sponsor:** Wayne State University School of Medicine, Division of CME. **Contact:** Gail Bank, PhD, Director, Continuing Medical Education, Wayne State University School of Medicine, 4201 St. Antoine, 4-H, Detroit 48201 (313)577-1180. **Approved for:** 12 hours Category I Credit.

25-28, Infectious Diseases. **Location:** Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** Michigan State University College of Osteopathic Medicine Alumni Association. **Contact:** Sandy Kilborn, Director of Continuing Medical Education, Michigan State University, College of Osteopathic Medicine, A306 East Fee Hall, East Lansing 48824-1316 (517)353-9714. **Approved for:** 10 hours of OAO Category I Credit.

July

17-18, Practical Approach to the Diagnosis and Management of Cardiopulmonary Diseases. **Location:** Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** Michigan State University College of Osteopathic Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 E. Fee Hall, East Lansing, MI 48824-1316. **Approved for:** 10 hours of Category I Credit.

30-31, Coller Penberthy Thirlby Medical Conference. **Location:** Grand Traverse Resort, Grand Traverse Village. **Sponsor:** Munson Medical Center. Traverse City. **Contact:** Norma Powers, Manager, Health Sciences Library/Medical Education, Munson Medical Center, Sixth and Madison Streets, Traverse City 49684 (616)922-9000. **Approved for:** 9 hours Category I Credit.

31-8/2, Tutorial on Level II Myofascial Release Technique. **Location:** The Homestead Resort, Glen Arbor. **Sponsor:** Michigan State University College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 East Fee Hall, East Lansing, MI 48824-1316. **Approved for:** 24 hours Category I Credit.

August

9-14, Symposium on Breast Disease: Diagnostic Imaging and Current Management. **Location:** Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** University of Michigan Medical School, Department of Radiology and Office of Continuing Medical Education. **Contact:** Gayle Fox, Office of Continuing Medical Education, The University of Michigan Medical School, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 20.3 hours of Category I Credit.

31-9/3, Advanced Cardiac Life Support Provider Course. (August 31 and September 2 Recertification Course—8 Category I Credits—4 for BCLS and 4 for ACLS). **Location:** Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Center, Staff and Patient Education Department. **Contact:** Claire A. Zieman, Staff and Patient Education, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-8320. **Approved for:** 25 Credits (4 for BCLS and 21 for ACLS).

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 40¢ per word, with a minimum charge of $20.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

MICHIGAN AND CARIBBEAN ISLAND—full time opportunities available in Emergency Department, Urgent Care Center and Industrial Clinic in Michigan and in well equipped Island Clinic. Excellent compensation, malpractice coverage, ideal working conditions. Michigan locations offer year round recreational opportunities on Lake Michigan. Contact: Professional Emergency Service, 5112 South Shore Drive, Whitehall 48461 (616)739-5509.

FAMILY PRACTITIONER BC/BE for Director of Health Center, Northern Michigan University, in Marquette—a regional medical center with full complement of medical specialists. Family oriented environment with recreational opportunities in scenic Upper Peninsula on shores of Lake Superior. Deliver medical care, coordinate services, consult on policy and provide preventive programming. Minimum: Michigan licensed/eligible; experience in office gynecology essential; interest in young people and preventive medical programs. Preferred: leadership abilities; administrative experience. Competitive salary/benefits. Send letter of application, resume, transcripts, credentials and 3 letters of recommendation to: John Hammang, Director of Human Resources, 204 Cohodas Administrative Center, Northern Michigan University, Marquette 49855 or call (906)227-2330. Deadline: screening begins April 20, 1987; position to be filled by June 20, 1987. An Equal Opportunity/Affirmative Action Employer.

FAMILY PRACTICE PHYSICIAN BC/BE: Wanted to join busy four man group in beautiful northeastern Michigan on Lake Huron. City/township population of 22,000, service area population 64,000. Exceptional summer and winter recreation area: sailing, scuba diving, boating, fishing, hunting, skiing, golf. Excellent opportunity, salary, benefits, partnership after one year. Contact: William Ray, Director, Medical Arts Clinic, PC, 211 Long Rapids Road, Alpena 49707. (517)354-2142.

OPHTHALMOLOGY SOUTHEASTERN WISCONSIN Large multi-specialty clinic located near Milwaukee is seeking a second BE/BC ophthalmologist. Non-surgical orientation preferred. Excellent salary and fringe benefits. Interested parties please send inquiries and CV to: Joe Scholl, Manager, Physician Recruitment, PO Box 427, Menomonee Falls, WI 53051.

WISCONSIN—LOCATED ON THE SCENIC WISCONSIN RIVER Full time emergency position available with an established department which has growing volume ED visits. Independent contractual relationship. Flexible scheduling with annual compensation between 100k-115k. Previous ED experience with pediatric background desired. Write or call collect: Jean Malkasian, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186, (414)785-6500.

FAMILY PRACTICE PHYSICIAN BE/BC WANTED Senior member of well managed two physician family practice corporation retiring August 1. Well established practice in south suburban Dayton, Ohio. Better-than-competitive salary, benefits, and profit sharing. Partnership opportunity. Ten physicians co-op for night/weekend call. Satellite hospital 1.5 and teaching parent hospital 7 miles from office. Full specialty back-up. No obstetrics. On site laboratory and x-ray. Outstanding cultural, educational, and recreational opportunities including those in nearby Cincinnati with major league sports. Contact Verne H. Dodson, MD, 1012 East Central Avenue, Miamisburg, Ohio 45342. Phone (513)866-1012.

PHYSICIAN FERRIS STATE COLLEGE Candidates must possess a medical degree from a recognized medical college, be licensed to practice medicine in Michigan. Board certification preferred in Family Practice or General Practice. To work full time with medical staff providing primary health care services to 11,000 students in an out-patient clinic setting. The candidate must also possess the ability to relate to and work with a college age population. $45,000—$50,000. Dependent upon education and experience. Health, life and dental insurance, malpractice insurance, retirement, sick leave, vacation leave and long-term disability. Send letter of application, resume and names of three references by May 15, 1987 to: Mr. M.C. Rhowmine, Administrator, Health Center, Ferris State College, Big Rapids 49307. An affirmative Action/Equal Opportunity Employer.

CHILD/ADOLESCENT PSYCHIATRIST Board eligible, preferred certified, to work closely with a multidisciplinary team in an accredited 40 bed child and adolescent psychiatric hospital, an agency of the Michigan Department of Mental Health. We are located in beautiful Traverse City, Michigan. A water and winter wonderland. Traverse City is the cultural and medical center for Northern Michigan. Skiing, fishing, hunting and sailing is at your doorstep. We have an excellent school system and a pollution free, low crime environment. Salary depending upon qualifications to $86,000 with remarkable fringe benefits. Send curriculum vitae and three letters of reference to Arnell Engstrom Children's Center, Box C, Traverse City 49684, or call Robert E. Davidson, MD or Paul Surratt, PhD, at (616)922-5400. An equal employment opportunity employer.

PHYSICIAN WANTED: Cardiology—Internal Medicine. To Buy within one to two years, large suburban practice, with non invasive clinic. Please respond to Box 102, Michigan Medicine, PO Box 950, East Lansing 48826-0950.

ARIZONA-BASED PHYSICIAN RECRUITMENT firm has quality opportunities coast to coast. Available positions in most primary care and surgical specialties to include OB/GYN, Orthopedics, ER, and ENT. "Quality Physicians for Quality Clients since 1972." Call (602)990-8080; or send CV to: Mitchell & Associates, Inc., PO Box 1804, Scottsdale, AZ 85252.

OB/GYN, ORTHOPEDIC SURGEON: Board certified or eligible to join 15 member group in progressive northwestern Wisconsin Community. Modern, well-equipped hospital located adjacent to our facility. Close to Minneapolis, Eau Claire and Duluth, the Rice Lake area offers excellent educational, religious and community activities in addition to exceptional sports, hunting, fishing, and recreational opportunities. For more detailed information regarding our group, please contact Mark T. Nymo, MD, Indianhead Medical Group, 1020 Lakeshore Drive, Rice Lake, WI 54868 (715)234-9031.

COLLEGE HEALTH PHYSICIAN to join 2 others in ambulatory care clinic at Central Michigan University. Excellent vacation, call, and retirement benefits. Recreational area. Must enjoy adolescent medicine but background can be Family Practice, Internal Medicine or Pediatrics. Inquiries to: G. Freeman, MD, Foust Hall, Central Michigan University, Mt. Pleasant 48859 (517)774-6588.

MEDICAL DIRECTOR St. Clair County Social Services Board is seeking applications for Medical Director and Attending Physician for St. Clair County Medical Centre, a 75-bed skilled nursing facility located in Goodells, Michigan. Qualifications required: 1)Graduate of an approved school of Medicine or Osteopathy. 2) Possession of a current, valid license to practice medicine or osteopathic medicine and surgery in Michigan. 3) Covered by own malpractice insurance. Qualified applicants should apply in writing to: St. Clair County Social Services Board, c/o administrator, 8332 County Park Drive, Goodells 48027. An Equal Opportunity Facility.

AN OUTPATIENT SURGICAL FACILITY located in Northwest Oakland County is seeking an Anesthesiologist for vacation relief. Please contact W.O.A.C.C., 1885 N. Pontiac Trail, Walled Lake 48088, or call (313)624-6635.

MICHIGAN: Emergency Department Directorships, full time and part time opportunities available throughout the state. Rural and urban locations. Guaranteed hourly rate and malpractice insurance

Continued on next page

CLASSIFIED/Continued

provided. Contact Emergency Consultants, Inc., One Windemere Place, Room 23, Petoskey 49770; 1-800-253-7092 or in Michigan 1-800-632-9650.

PEDIATRICS—SOUTHEASTERN WISCONSIN. Large multi-specialty group located near Milwaukee is seeking a fourth BE/BC pediatrician. Competitive salary; excellent fringe benefits. Address inquiries and CV to Administrator, PO Box 427, Menomonee Falls, Wisconsin 53051.

ANESTHESIOLOGIST WANTED to join Central Wisconsin Anesthesiology, S.C. which consists of four established, hospital based anesthesiologists. All specialties are served including open heart, neuro, obstetrics and gynecology. If interested, phone (715)845-5505 or write to: Central Wisconsin Anesthesiology, SC, 425 Pine Ridge Blvd., Suite 207, Wausau, WI 54401.

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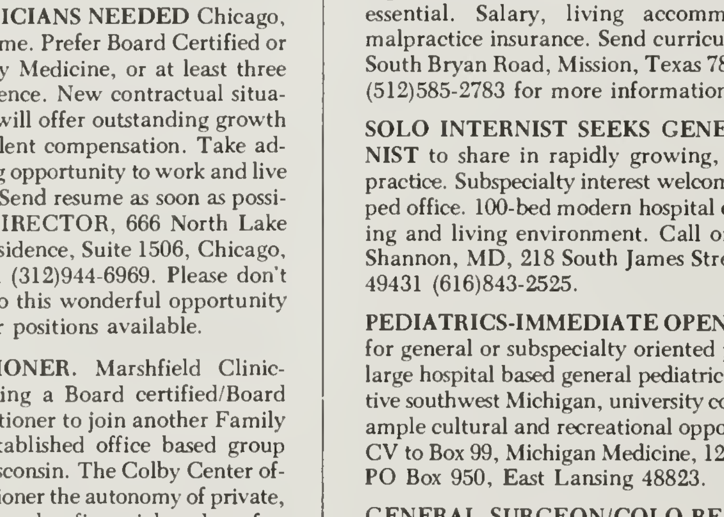

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Taking charge of change

By Thomas R. Berglund, MD

The title of this, my last President's Page, was the theme of the AMA's Leadership Conference this past February. If I can leave any message with you, it is that there have been and will be changes in the way we practice medicine.

In my inaugural address, published on this page a year ago, I detailed the many changes that had taken place in the practice of medicine in the past 50 years, including antibiotics, immunizations, various drug therapies, diagnostic imaging and various innovative surgeries.

We all have seen tremendous changes in reimbursement mechanisms. We no longer have only fee for service. There are HMOs, PPAs and various other insurance plans. Insurance companies also are changing. The are requiring second surgical opinions, same-day surgery, pre-admission certification, as well as other changes in their attempt to lower health care costs.

Hospitals really are changing. Some have closed. Others have developed various marketing plans designed to bring in patients to fill empty beds. Helicopters are everywhere. Much more intensive care is being given. And how many of you thought that you would see hospitals advertise on billboards, radio and TV?

The Federal Government also is changing its relationship with medicine. It is paying hospitals by diagnosis related groups, has frozen physician fees and is attempting to institute DRGs for radiologists, anesthesiologists and pathologists. That also will change for the rest of us.

Thomas R. Berglund, MD

More sophisticated

Over my years of involvement the Michigan State Medical Society has changed. The talent has improved and we have a much better staff now. Various programs have been discarded and others improved. One major example is the MSMS lobbying effort. Twenty-five years ago we were very ineffective, while today we are among the best in Lansing.

Also the political arena has changed. Michigan Doctors Political Action Committee (MDPAC) started as a small group. It has grown to 3,500 members and almost 600 of them are sustaining members—quite a good change. MDPAC also has changed in that it is much more sophisticated.

Issues have changed. We have gone through not one but two professional liability crises. And smoking is well recognized as a major health hazard—it is no longer fashionable to smoke.

As I prepare to resume full practice again I look forward to many more changes in the years to come. There will be new drugs to learn to use, new physicians with new skills to refer to and changing patterns of practice. The government, insurance companies and society will continue to change.

Since I was trained as a physician and enjoy practicing as one, I look forward to "taking charge of change" so I can work past the year 2000.

It has been a great pleasure to have served my profession over the past 25 years. Being your president has been an extreme honor. I thank, especially, the very able MSMS staff for their great support over the years. I also thank the physicians of Michigan for electing me to this post.

About the time this is published another significant change will occur at MSMS as Carl Gagliardi, MD, is installed as president. Having known, worked with and admired Carl for years, I can assure you that he is ready to "take charge of change."☐

MICHIGAN
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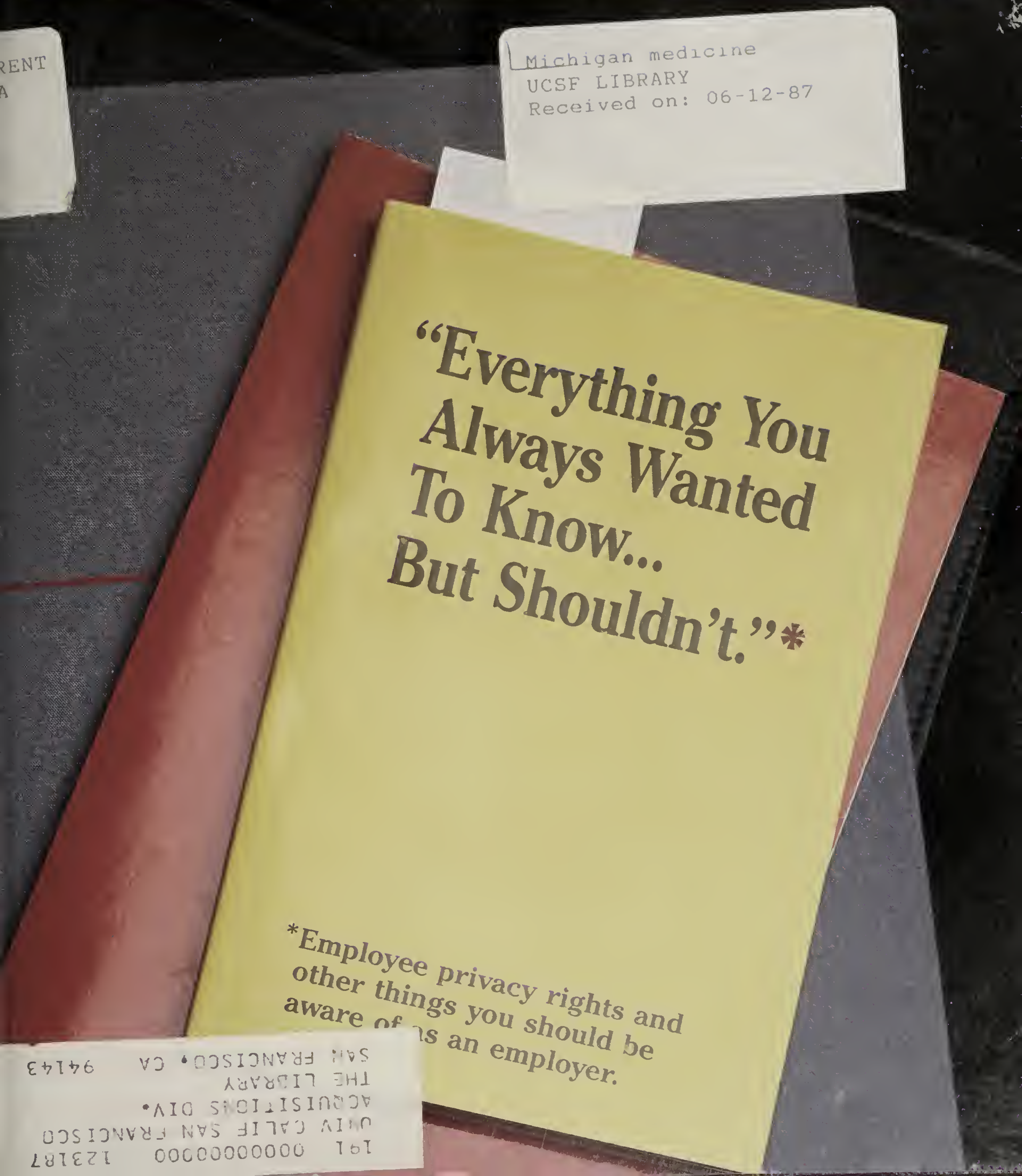
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*Employee privacy rights and other things you should be aware of as an employer.

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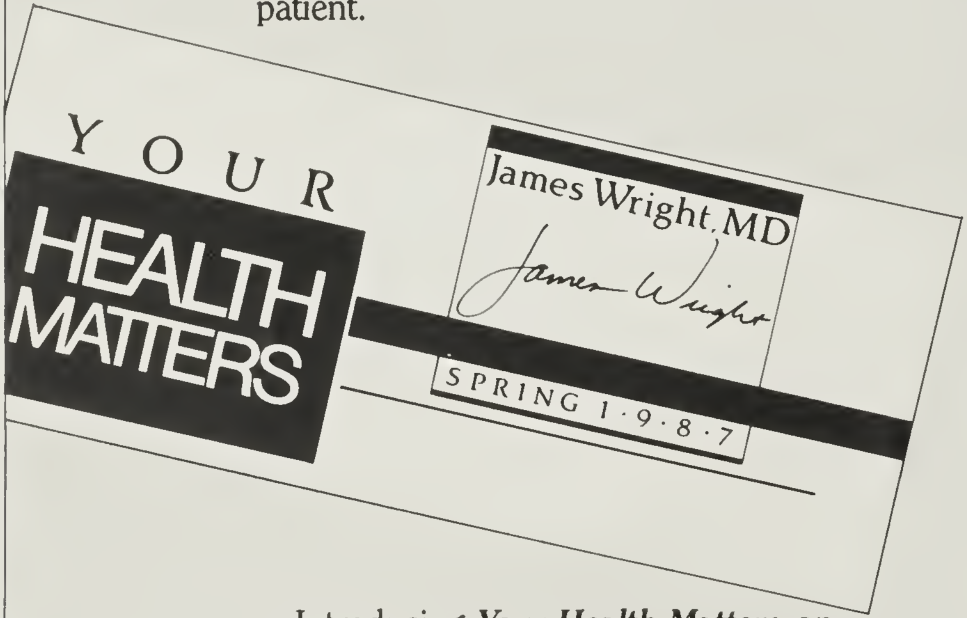

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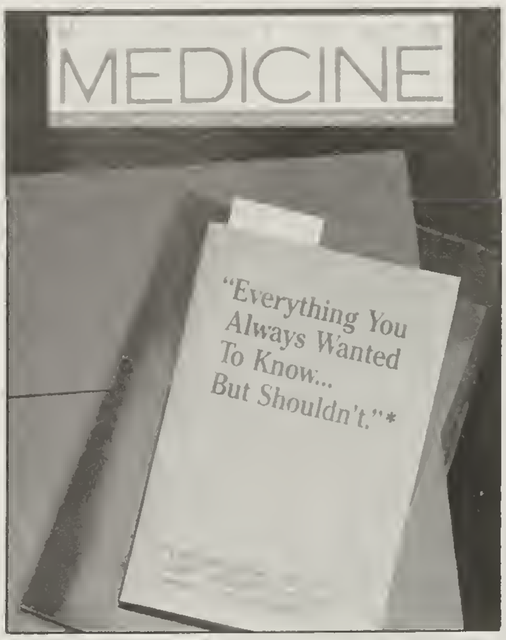
Special Report

Physicians as employers — it's a complicated business! And to help you keep up with what's new in the world of work, *Michigan Medicine* highlights a few relevant topics. Employee privacy rights, or "Everything you always wanted to know, but shouldn't," are spelled out for you here, as are steps to take when you're faced with firing someone. Physicians should take note, too, of Michigan's "Right to Know Law" regarding hazardous materials in the workplace. 298



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In next month's issue of *Michigan Medicine:* A look at infant mortality in Michigan.

Cover photo by Kim Kauffman.

Conference reinforces merit of Fleming's report

By Richard J. McMurray, MD

Doctor McMurray

The author, Doctor McMurray, is a member, MSMS Committee on Publications.

Your state medical society in association with the Michigan Section of the American College of Obstetricians and Gynecologists, and under the direction of the Maternal and Perinatal Health Committee of MSMS, has again provided an excellent meeting for obstetricians, family practitioners, pediatricians and nurses who provide care in that area.

That meeting was the 1987 Michigan Conference on Maternal and Perinatal Health, held March 25-26 at the Hyatt Regency Dearborn. We were welcomed by Carl Gagliardi, MD, a pediatrician, now MSMS president. Doctor Gagliardi stressed for us the importance of quality medical care, and that meetings of this nature obviously were designed to enhance our ability to deliver quality care. He also reviewed the effect of past legislative efforts in the field of medical liability and outlined the initiatives that have been undertaken this year by the MSMS Task Force on Professional Liability.

As the speakers developed their topics for discussion under the general theme, "Preparing for the 90s: Controversies in Care," all 'bets were coppered' with continual concerns of medical liability. The messages outlined efforts which must be made by the profession to deliver the type of care our patients deserve, at a price they can afford, and still protect ourselves and our hospitals from medical liability suits.

Gerald H. Mandell, MD,

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. *Michigan Medicine* reserves the right to accept or reject advertising copy. Products and services advertised in *Michigan Medicine* are neither endorsed nor warranted by MSMS.

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speaker of the MSMS House of Delegates, and president of Medical Associations for Risk Management (MARM) also made a presentation. And as important as risk management is, and as nebulous as some aspects of it may be, the general theme prevails that we still have liability problems. Doctor Mandell pointed out that if all physicians practiced 99.9 percent perfect medicine, with the number of patient-physician encounters per year, we still would see the filing of nearly 3,800 cases per year (which is about the number now being filed).

A few weeks ago you all received in *Medigram* a detailed summary of the final report of Robben Fleming, PhD. I certainly hope you took time to read this report. He has made observations that warrant promoting:

1. Medical liability now involves more maloccurance than malpractice.
2. The tort system is not the forum for the resolution of these maloccurances.

About one year ago I made a literary attempt in *Michigan Medicine,* "The Coincidental Poor Result" (CPR). I tried to express this theme as an idea whose time has come. In Doctor Fleming's report he has expressed it much better, but I would also refer you to April, 1986 *Michigan Medicine* for a review of CPR. I believe that as a profession and as a total society, we should pursue and develop the Fleming report and an idea "whose time has come." That's my opinion. ☐

Michigan House wants to hear more

Thank you for the recent issue of *Medigram*. In the January 20, 1987 issue, topics that were covered at the Annual State Health Legislation meeting were mentioned.

Of particular interest to us are the tort reforms Arizona doctors recently initiated, as mentioned by Doctor Paxton. We would greatly appreciate any further information on the Arizona tort reform proposals or possible contacts that you could provide.

Again, thank you for an informative newsletter and any help you may be able to provide.

Susan Gbur
Legislative Intern
Michigan House of
Representatives

PAs promote safer workplace

We are writing in reference to occupational health issues, and seek exposure to your many readers.

The American Academy of Physicians Assistants in Occupational Medicine (AAPA-OM) is the professional association for physician assistants who provide health care for workers with job related illnesses and injuries. It is the focus of this organization to promote to its members the highest professional medical standards as they provide medical care to the nation's work force.

We promote programs that lead toward a safer and healthier workplace environment through health promotion, management consulting and medical monitoring.

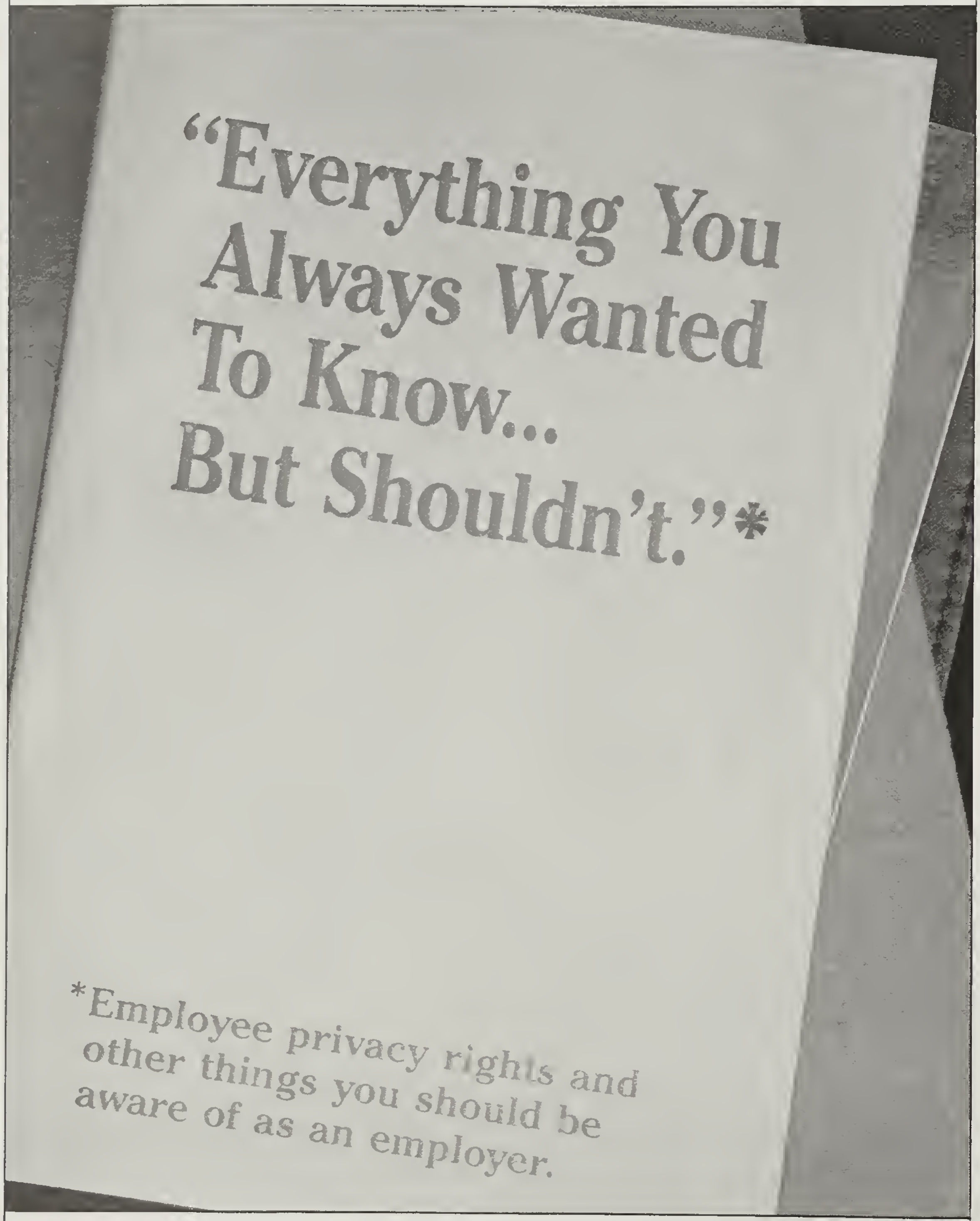
We strive to develop and expand the physicians assistant's integral role on the occupational health team through close interface with management, supervising physicians, occupational health nurses, industrial hygienists and safety engineers.

The AAPA-OM seeks members and the exchange of ideas and opportunities. For further information or membership write AAPA-OM, PO Box 53164, Oklahoma City, OK 73125.

We appreciate your assistance in helping AAPA-OM become known to others in the occupational health field. Thank you in advance for your cooperation.

Rosalie Hutchinson, PA-C
David Mongillo, PA-C
AAPA-OM Membership
Committee

Physicians as employers: a complicated business



"Everything You Always Wanted To Know... But Shouldn't."*
*Employee privacy rights and other things you should be aware of as an employer.

Being a physician is a complicated business these days.

Though physicians might like to occupy themselves solely with the art and science of medicine, many are employers as well.

This month's special report in *Michigan Medicine* addresses the employer side of the multifaceted medical practitioner.

You will find information on employees' privacy rights, Michigan's right to know law, firing techniques and health benefits rules under the new Consolidated Omnibus Budget Reduction Act (COBRA).

The materials summarized here have been gathered with the help of MSMS legal counsel and of the MSMS Physician Service Group, Inc. (PSG). Both are ready to help you with further details in all of these areas.

Among the PSG offerings for Michigan physicians are a continuing series of practice management seminars for residents about to begin practice. The seminars are scheduled on an ad hoc basis through Michigan hospitals for their residents.

For further details on the physician as employer, you may contact John Richards, general manager, PSG, 1305 Abbott Road, East Lansing 48823. □

Employee privacy rights:

"Everything you always wanted to know — but shouldn't"

By John Patrick White and Thomas J. Barnes

In an Orwellian age when the ability to gather, store and retrieve information has reached unparalleled proportions, concern over the use, misuse and abuse of such information continues to grow. Acts such as the Freedom of Information Act, Fair Credit Reporting Act, the Privacy Act of 1974 and the Family Rights and Educational Privacy Act have been passed in an attempt to provide both control and balance between the government's and private sector's need for information and the citizenry's right to know about and control the use of that information. This societal concern over personal autonomy and privacy has, understandably, spread to the workplace.

This article provides a broad overview of the types of privacy issues emerging in the workplace. The authors caution that there are relatively few definitive answers in this particular area of the law. Despite the legal principles involved, the workplace privacy issue is essentially a question of positive employee relations. The intent of this article, therefore, is to familiarize the practitioner with the general issues and to provide a positive approach to balancing the employer's right and need to manage the work force with the reasonable privacy expectations of its employees.

For convenience, privacy issues relating to the hiring process are presented first, followed by privacy considerations arising from and during actual employment. Finally, predictions as to trends in the law and suggestions on preventative measures are offered.

John Patrick White is associated with the firm of Varnum, Riddering, Schmidt & Howlett in Grand Rapids. Thomas J. Barnes is a partner in the same firm, representing employers in labor and employment relations law. These excerpts reprinted with permission from the October, 1985 *Michigan Bar Journal*.

The hiring phase

Historically, employers were free to ask almost any question and gather any information they desired during the application process. The employee, of course, always retained the right not to answer, but the employer had no requirement to hire a recalcitrant applicant. Should the applicant disclose the requested information or authorize disclosure of the information, the defense of waiver was established to any subsequent claims of invasion of privacy.

The advent of civil rights laws, however, has curtailed the scope of the information which may be legitimately requested. These laws have indirectly created a zone of privacy for information which is unrelated to qualifications for a particular position and which proportionately stigmatizes a protected class of individuals. Any information procured is subject to disparate impact analysis to determine whether the information, although facially neutral, disproportionately and adversely impacts upon a protected class. Therefore, every question asked or piece of information gathered during the application process should have rational basis concerning the employment decision.

The Michigan Civil Rights Commission, for example, publishes a Pre-employment Inquiry Guide which lists various types of information which should not be elicited during the pre-employment phase. Except where there are bona fide occupational requirements, asking the person's age, race, religion, height, weight, marital status, sex, national origin and non-job related mental or physical impairments is inherently suspect. Singularly, inquiries into arrests, rather than convictions, for criminal offenses are generally prohibited.

Also, in light of several Michigan cases holding that it is improper to discharge an employee or refuse to hire an applicant based on previous workers' disability compensation claims, inquiries into previous job-related injuries which do not impair present capabilities should also be avoided. The presumption is that any information gathered is used in the determination process. The inadvertent gathering of irrelevant information, therefore, creates an unnecessary potential for liability.

The Michigan Polygraph Pro-

Continued on next page

tection Act of 1981 also provides a significant protection of applicant/employee privacy. Under the Act, it is illegal for an employer or employment agency to either request or require an applicant or employee to submit to a polygraph examination, and employment may not be refused because the applicant declines the offer of a polygraph examination. Given the concerns over the reliability of polygraph results and their general inadmissibility in court proceedings, the Act should not be viewed as disfavoring employer interests. It does show, however, a legislative interest in employee protection.

An applicant or employee may voluntarily request to take a polygraph examination, but the employer can not take any adverse action based on the examiner's conclusion that the applicant or employee was not truthful in his or her answers during the examination. The applicant or employee must be informed in advance of all areas of questioning, and may not be questioned about sexual practices, labor union, political or religious affiliation, or marital relationships, except where the question has a direct bearing on the issue under examination. Unless the applicant chooses to request a polygraph exam to serve as a confessional, little useful information can be gained.

The restricted areas of inquiry raise the question of whether the licensing statute for polygraph examiners establishes a public policy against inquiry into sexual practices, the marital relationship and/or political affiliations. With Michigan's acceptance of the theory that employees may not be discharged in violation of the public policy of the state, employers would be well-advised to avoid inquiry into or action based on these particular areas, unless there is overriding business justification for such inquiry or action.

Clearly, an applicant for employment need not bare all the personal facts of his or her life to procure employment.

An additional restriction on the collection and use of information is contained in the federal Fair Credit Reporting Act. An employer who requests an investigative consumer report from a consumer reporting agency must disclose to the applicant or employee that a report including information as to character, general reputation, personal characteristics and mode of living may be made. Such disclosure must be made in writing and mailed or delivered to the applicant or employee not less than three days after the report is requested.

Various exceptions are available, and the consumer reporting agency generally is responsible for the accuracy of the report. Informing an applicant early on if such checks are routinely made may help to avoid the sense of indignation that comes from an unexpected intrusion into what can be a very personal matter, consumer debt.

Public employers operate under the additional burden of the constitutional guarantees that accompany employees into the workplace. Courts have consistently held that an employee may not be required to waive his/her constitutional rights as a condition of employment with the government. The right to privacy, like other constitutional rights, is not absolute, but the government must justify its intrusion into personal matters by establishing a legitimate need.

Due to the "constitutional" considerations involved, the balancing of need versus degree of intrusion probably is more closely scrutinized in the public sector than the private sector. The information gathered in the application and screening process, therefore, must be both relevant and not overly intrusive.

Clearly, an applicant for employment need not bare all the personal facts of his or her life to procure employment. The onus is shifting, if it has not in fact already shifted, to the employer to justify the need for the information sought. The employer who never gathers facts unrelated to job qualification will not run the risk of either impermissively acting on or inadvertently disclosing improper information. Qualification, not curiosity, is the watchword for screening applicants.

Informational privacy

In this ever advancing society all are concerned that the individual's integrity and independence are not obliterated by the dissemination of unnecessary information.

— *G. Mennen Williams*

The modern employment relationship is heavily regulated. Numerous governmental agencies require employers to keep records pertaining to various aspects of the employment relationship. In addition, the employer often maintains records on individual productivity, attendance and discipline. Where the information gathered is required by the government or justified by business necessity, unwarranted intrusion is unlikely.

The difficulty, however, arises from the use and dissemination of information which was originally gathered for a legitimate purpose. For example, information on an employee's age, marital status, dependents, national origin, height, weight and physical or mental ailments may be necessary for proper processing of government reports, the pre-employment physical, payroll records and health insurance forms. This information, although of possible interest, probably has little relevance to the job the supervisor must perform in directing and evaluating the performance of an employee.

Similarly, performance evaluations and disciplinary records have little relevance to payroll or medical personnel. One can understand how an employee who files an insurance claim for a mastectomy or treatment of venereal disease might be offended if the claim became the subject of idle gossip in the workplace due to inappropriate disclosure of that information.

Although there is a qualified privilege to disclose information to persons within the organization who have a need to know, this is a limited privilege, and employees are starting to challenge dislosure of such information.

Access rights and constraints are imposed on federal agencies by the Privacy Act of 1974. That Act requires each government agency to maintain and publish a system of records so that employees can be reasonably informed of the types of records that exist. The employee has a right, with limited exceptions, to request access to any information in the system which pertains to him or her. The Act also provides restrictions on agency disclosure of records pertaining to an employee without the prior, written consent of the employee.

The potential for abuse of information and invasion of informational privacy continues to escalate as the store of information grows on individual employees. Waiver of the right to privacy exists only to the extent legitimately necessary and proper to deal with a specific situation. Thus, even though an employee originally provides information, he or she may still claim an invasion of privacy for the subsequent disclosure of that information. Procedures should be implemented to assure that information collected on employees is necessary to a legitimate business function and is restricted to those with a need to know.

Behavioral privacy

Perhaps the more troubling and difficult issues revolve around behavioral privacy or personal autonomy. These privacy issues commonly arise in the workplace from the search of employees and their possessions, surveillance and regulation of conduct outside work. There are few hard and fast rules governing permissible conduct in these areas. Numerous variables affect the balance, including whether the employee is unionized, whether the individual is employed in the public or private sector and who hears the dispute.

Even within these parameters, there is a wide variance in interpretation of the privacy rights to which an employee is entitled, primarily because each case is fact intensive and involves a balancing of the degree of intrusion on the employee's legitimate expectation of privacy against the

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PRIVACY/Continued

justification for the employer's intrusion.

The search of employees and their possessions provides one of the most direct examples of employer intrusion into employee privacy. Based on Fourth Amendment concepts, employees often expect not to be searched by anyone, absent a search warrant. In fact, the Fourth Amendment probably does limit the ability of a public employer to institute individually focused searches, although the standard more likely involves reasonable suspicion rather than probable cause to conduct a noncriminal investigation.

Judicial interpretations of the Constitution have also developed a general expectation to be free from unjustified interference with certain personal decisions relating to associations, marriage, procreation, contraception, family relationships and child rearing and education. The Fifth Amendment's guarantee against self-incrimination also raises expectations which employees have carried into the workplace. Although these constitutionally-based rights are directed at governmental intrusion, the average employee does not readily appreciate the fine distinction between governmental and private intrusions.

Perhaps the distinction is fading anyway. The right to privacy continues to gain broader application in both the public and private sectors. Michigan, like most jurisdictions, has adopted Prosser's definition of invasion of privacy, which includes "intrusion upon the plaintiff's seclusion or solitude, or into his private affairs." The tort gives rise to a zone of privacy into which outsiders, including employers, may not intrude without justification. Also, courts appear increasingly willing to impose constitutional restrictions on private entities, finding certain basic civil liberties inure to the individual.

In general, however, employers have received the right to make reasonable searches of employees where a legitimate need exists. Thus, in *Wisconsin Steel Coal Mines,* Arbitrator Marlin M. Volz upheld routine pat-down searches of employees for smoking materials. Noting that federal law mandates the employer to provide a safe workplace and also prohibits smoking in the mines, he rejected the grievant's proposed alternative of emptying his pockets as being neither as effective nor time-efficient as the pat-down method. The arbitrator also noted that the searches for smoking materials were a known condition of employment.

This notice factor is an important aspect in privacy decisions, as the employee must have a legitimate expectation of privacy to claim an invasion of privacy. Thus where the employer has a clearly communicated rule involving searches, legitimate expectations of privacy are reduced. Such rules, particularly in the unionized and public sector settings, must withstand the test of reasonableness; they must be rationally related to a legitimate business need and, to the extent possible, be the least intrusive method for meeting that need.

With the increasing concern over alcohol and drug abuse in the workplace, new privacy controversies are likely to arise over the use of screening devices such as breathalyzers, blood testing and urinalysis. Estimates indicate that approximately 20 percent of the Fortune 500 companies either have instituted or are seriously looking into drug screening for job applicants. Discrimination issues aside, such testing of applicants probably qualifies as a consensual intrusion.

In the non-union sector, the right to require such testing of existing employees will again depend on the balance between employers' legitimate needs (some of which may, unfortunately, turn on medical opinions which are vague or inconclusive) and the degree of intrusiveness. Neither the courts nor the Legislature should be expected to remain passive if basic civil liberties in the workplace are intruded upon, particularly where such screening also raises the related privacy question of the extent to which an employer may regulate activities engaged in on an employee's personal time.

In one of the few reported opinions addressing this type of testing in the workplace, Arbitrator Maurice Trotta disallowed discipline imposed for an employee's refusal to take a urine test to confirm suspected drug use, finding the employer's policy unclear as to potential discipline. His opinion raised, but did not answer, concerns about the control and ultimate use of the results of such testing beyond the workplace. Arbitrator Irving Markowitz, however, disallowed privacy claims based on the unconsented extracting of blood alcohol samples at the emergency room from an unconscious employee, finding that the wife's consent for treatment and the employee's subsequent release of the medical records to the company waived any privacy claim.

Trends and preventative measures

Although some commentators have asserted that non-unionized employees have no right to privacy once they enter the workplace, the statement is misleading. Employers, as well as those who counsel them, would be ill-advised to assume that applicants and employees have no rights to personal privacy. In Michigan, as in other jurisdictions, employee rights in the workplace have continued to expand. Erosion of the at-will employment concept and statutory restrictions on employer autonomy must be considered as indicators of increased judicial and legislative recognition and acceptance of employee rights in the workplace. This general trend will likely result in increased litigation over and recognition of basic employee privacy rights in the workplace.

With the increasing concern over alcohol and drug abuse in the workplace, new privacy controversies are likely to arise over the use of screening devices such as breathalyzers, blood testing and urinalysis.

Employers, however, can do much to minimize potential morale problems and legal challenges based on employee privacy concerns by doing some basic review and planning in their personnel policies and practices. The following suggestions are offered to assist employers and counselors to structure an appropriate balance between the needs of the business and employee privacy concerns.

Informational privacy

1. Review the employment application process to be certain that all information collected is necessary and relevant to processing the application and determining qualifications for the particular position sought. If outside reference or credit checks are to be made, clearly disclose this on the application and procure a release from the applicant.

2. Be certain that the source of all information, as well as the time, date and person receiving it, is reflected in the personnel file. Anonymous notes to the file are worthless to the careful employer and offensive to the employee's sense of fairness.

3. Establish separate subsections in the personnel file to segregate various types of information, i.e., performance information, payroll information, medical information, background or general information.

4. Restrict access to and discussion of information contained within the personnel file only to those within the company who have a demonstrated need to know and third parties who are authorized either by law or by the employee to have access.

5. Standardize the process for requesting information from personnel files and be certain that each person responsible for custody of personnel files is familiar with the company's policies both on gathering and releasing information.

6. Develop a consistent policy regarding release of information to third parties. Generally, this should only be on written request and with written employee consent, and the information released should be strictly limited to the scope of the consent. Do not rely on a general waiver by

Continued on next page

the employee executed at the time of his/her application for employment.

7. Maintain a log of access to and use of the personnel file to monitor possible abuse of personnel files. Foremen, for example, generally have little need for access to payroll or background information. Similarly, the payroll department has little need for general access to performance and disciplinary records. Employee review of the file should also be logged.

8. Conduct periodic reviews of personnel files to remove outdated and unnecessary information. Records that are outdated should either be destroyed or placed into a limited access archive away from the active personnel file. Prior to destruction of any document, check record retention requirements of regulatory agencies and determine relevance to any pending potential lawsuits.

9. Inform employees of company privacy guidelines and designate an individual to whom the employees can express concerns about their individual privacy.

Behavioral privacy

1. Identify those areas in which the employer has a legitimate need to intrude into an employee's "zone of privacy." Anticipate employee sensibilities. Specific problem areas should be identified with supporting facts. Alternative solutions should be outlined and assessed for the degree of intrusiveness versus its effectiveness in remedying the identified problem. Records of considerations may be helpful in justifying actions and good faith if actions are subsequently challenged.

The potential for abuse of information and invasion of informational privacy continues to escalate as the store of information grows on individual employees.

2. Select the least intrusive, effective solution. For example, a metal detector is less intrusive than a pat-down or strip search for weapons entering or parts leaving a plant. In a unionized setting, care must be taken to adhere to the collective bargaining agreement and fulfill the duty to bargain regarding changes in the conditions of employment. Even in the non-unionized setting, some employee involvement in addressing a given business concern may ease employee resentment when a policy is subsequently adopted.

3. Publish and post any policy adopted. Employee awareness of the policy minimizes expectations of privacy and hopefully reduces the chance of resistance. The policy should clearly state the procedure that will be implemented by the company and the discipline that may be imposed for refusal to comply. Where feasible, give a brief explanation of the reason for the policy and to whom questions can be directed. For example:

Lockers are provided for your personal convenience. For security and inventory control, these lockers and their contents may be inspected at any time without warning. Failure to permit inspection of the contents of a locker under your control may result in discipline, including discharge. Questions regarding use of these lockers should be addressed to the Personnel Director.

4. Train supervisors in the employer's policy and practice regarding searches and surveillance. Supervisors should feel competent as to what they can do and knowledgeable as to what they cannot do in a specific confrontation. Generally, there is less liability for discharging an employee for refusal to cooperate than for conducting an unconsented to search. Employees, however, should be aware of the consequences for failure to cooperate.

5. Where suspected criminal activity is involved, contact the appropriate authorities and proceed accordingly. A properly conducted criminal investigation should insulate the employer from most potential invasion of privacy claims. ☐

Steps to terminating an employee: how can there be a graceful exit?

No one likes to be the "heavy," the bearer of bad tidings, the one to terminate an employee. However, sometimes performance has become so marginal or unsatisfactory that dismissal is a change that is necessary. Before determining a course of action, though, you must decide if the employee is a potentially good one who can be salvaged. The following checklist should be helpful:

1. Does the employee know the requirements of the job? ("What? I didn't know I would be required to assist the doctor!")
2. Did someone personally go over the job description, step by step, with the employee?
3. Does the employee actually know how to perform each task?
4. Has someone adequately trained the employee and then determined how well the tasks were performed?
5. Does the employee really know how he or she is doing? ("Gee, I thought I was making the appointments OK. No one ever told me I wasn't.")
6. Is the employee capable of performing these job duties?
7. Is he or she willing to perform the necessary job duties?
8. Was a performance review held with the employee three months after hiring and then at least annually thereafter?

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First Conference:

- Your goal here is to identify the problem and with input from the employee, find a mutually workable solution. This is not accomplished by demeaning the employee. Encourage the employee to make suggestions on how performance can be improved.
- Use the checklist as a basis for this session.
- Document accurately what was discussed and agreed upon. This can be done in an informal memo to the employee.

Second Conference:

- If the deadlines set at the first session have not been met, and if there has been little or no improvement, it is time for a second conference.
- Clearly define your expectations in writing with a definite date. Include a paragraph that states the employee understands that if he or she does not comply, this will constitute a lack of desire to remain employed and will result in termination.
- Ask the employee to decide if he or she wishes to remain or quit now.
- Use an "Employee Disciplinary" form to document this session.

Termination conference or "exit interview"

- This conference is the "third strike" — now the employee is out!
- Point out the past promises the employee has not kept. Specifically outline offenses. Ask the employee if he or she prefers to resign. If so, ask for a resignation letter.
- Schedule this talk for 5:00 p.m. Friday would be the best day. Have the payroll check ready including vacation, sick days, and severance pay. (Severance pay should be based on the reason for termination, as well as your office policy manual guidelines.) If the employee is vested in your pension plan, arrange to pay this amount promptly.
- Your decision is effective immediately! It is not wise to discharge an employee and allow him or her to remain on the premises longer than necessary. Often a discharged employee becomes disruptive.
- A complete documentation of this conference should be made. Ask the employee to sign it. (An employee cannot be compelled to sign any document.) If the employee refuses to sign, a witness should sign a statement verifying the refusal of the employee to sign the document. This is needed only to prove that the employee was aware of the document.
- Collect the employee's keys to the office, drawers, files, etc.

Now that this "mission has been accomplished," the office manager should make sure that business is conducted as usual — or even better! □

A review of Michigan's right to know law

By Thomas R. Williams

For several years there has been increasing concern about employees' safety in working around hazardous chemicals. This concern culminated in 1985 with federal regulations promulgated by the Occupational Safety and Health Administration (OSHA) and a Michigan statute known as the "Right to Know" law. The Michigan statute, which became effective April 17, 1986, and which is enforced by the Michigan Occupational Safety and Health Administration (MIOSHA) and the Michigan Department of Public Health (MDPH), is more comprehensive than the federal regulations. Effective February 20, 1987, the Michigan Right to Know law applies to any employer in the state of Michigan who employs more than one person.

Federal regulations have been effective since November 25, 1985 for chemical manufacturers and importers. In addition, effective May 25, 1986, employers within certain industries were to have implemented hazard communication programs to inform and warn their workers about hazardous chemicals on the work site.

Since the Michigan statute embodies and goes beyond the federal regulations, it is important for all employers to understand their obligations under the statute and the penalties involved for non-compliance.

From the outset, it is also important for employers to realize that the law applies only to hazardous chemicals which are known to be present in the workplace in such a manner that employees may be exposed to them to a significant extent under normal conditions of use or in a foreseeable emergency. Chemical manufacturers and importers, and not employers in general, make the determination of what chemicals are in fact hazardous.

The following is a summary of the primary areas of employer responsibility under the statute.

Mr. Williams is an attorney with the firm Kerr, Russell and Weber, Detroit, MSMS legal counsel.

Employer responsibilities

Under the Right to Know law employees are afforded protection from any discrimination or discharge resulting from requests for information regarding hazardous chemicals. The law does not, however, grant an employee a right to refuse to work around hazardous chemicals once the employer has informed the employee of the hazards and appropriate precautions to be taken, including the employer's provision of personal protective equipment.

Labeling

An employer's primary responsibility in this area is to inspect hazardous chemicals received from chemical manufacturers, importers and distributors to insure that containers are properly labeled, tagged or marked with the identity of the hazardous chemical, appropriate hazard warnings, and the names and addresses of the manufacturer and other responsible parties.

The label is to serve as an immediate warning to employees of the hazards in the workplace. The label must contain an identity of the hazardous chemical and appropriate warnings about what harm the body will experience upon exposure. The warnings are to be as specific as possible. In addition, the name and address of the manufacturer as well as the name and address of the responsible person who prepared the label must be indicated. The label must also indicate that additional information is readily available to employees at the work site concerning the product.

Pipes or piping systems in a workplace which contain hazardous chemicals must have a label conveying the same information required on container labels.

There are certain exemptions from an employer's requirement to inspect labels. The requirements do not apply to a chemical in a sealed package which is in transit by common carrier if the seal remains intact while in transit. In addition, a sign may be posted in lieu of individual container labels, if there are a number of stationary containers within a work area which have similar contents and hazards. In addition, employers are not required to label portable containers into which hazardous chemicals are transferred from labeled containers and which are intended only for the immediate use of the employee who makes the transfer.

The following products are exempt from labeling requirements:

Pesticides and herbicides
Foods and cosmetics
Distilled spirits
Consumer products
Hazardous substances

Material safety data sheets

Chemical manufacturers, importers and distributors are responsible for preparing complete and accurate Material Safety Data Sheets (MSDS) for hazardous chemicals which are delivered to employers. An MSDS is a separate document which should be received at the same time as the chemical product. Employers are responsible for checking each MSDS for accuracy and filing and maintaining all MSDS on the work site for employee access and review. In the case of construction operations, MSDS may be maintained in one central location at a job site.

Employers must also have a poster on the work site informing employees of the location of MSDS.

At a minimum, each MSDS must contain thirteen items of information:

1. The identity of the chemical
2. Chemical and common names (may be the same as label identity)
3. Physical and chemical characteristics of the substance
4. Physical hazards
5. Health hazards
6. Primary routes of entry (e.g. inhalation)
7. Air exposure limits
8. Carcinogenicity
9. Precautions for safe handling and use
10. Control measures
11. Emergency and first aid procedures
12. Date of preparation of MSDS
13. Name, address and phone number of MSDS preparer

The employer must review the MSDS for accuracy and insure that there are no blank spaces. The employer should communicate immediately with the manufacturer, importer or distributor, or the responsible person who prepared the MSDS, with any questions or concerns related to the MSDS. If an employer has continuing problems with several MSDS from the same source, the employer should contact MIOSHA and MDPH.

When an employer receives a revised MSDS setting forth new information about a hazardous chemical, he must post (for a period of ten (10) working days) a notice of the existence of a new or revised sheet. Employees then have the right to review the information contained in the new MSDS.

Written hazard communication program

Each employer must develop and have on the work site a written Hazard Communication Program. The program must contain information about labels, location and access of MSDS, a list of hazardous chemicals on the work site, including non-routine test hazards, and general information on employee training and information.

Employee information and training

Each employer is responsible for providing training to employees which must consist of the following:

1. The existence of the law and employee rights under the law.
2. How the Hazard Communication Plan is implemented at the work site.
3. How to read and interpret information on labels and MSDS.
4. How employees can obtain and use available hazard information.
5. What hazardous chemicals are on the work site.
6. Measures employees can and should take to protect themselves from hazards.
7. Specific procedures in effect by the employer to provide protection such as work practices and the use of personal protective equipment. □

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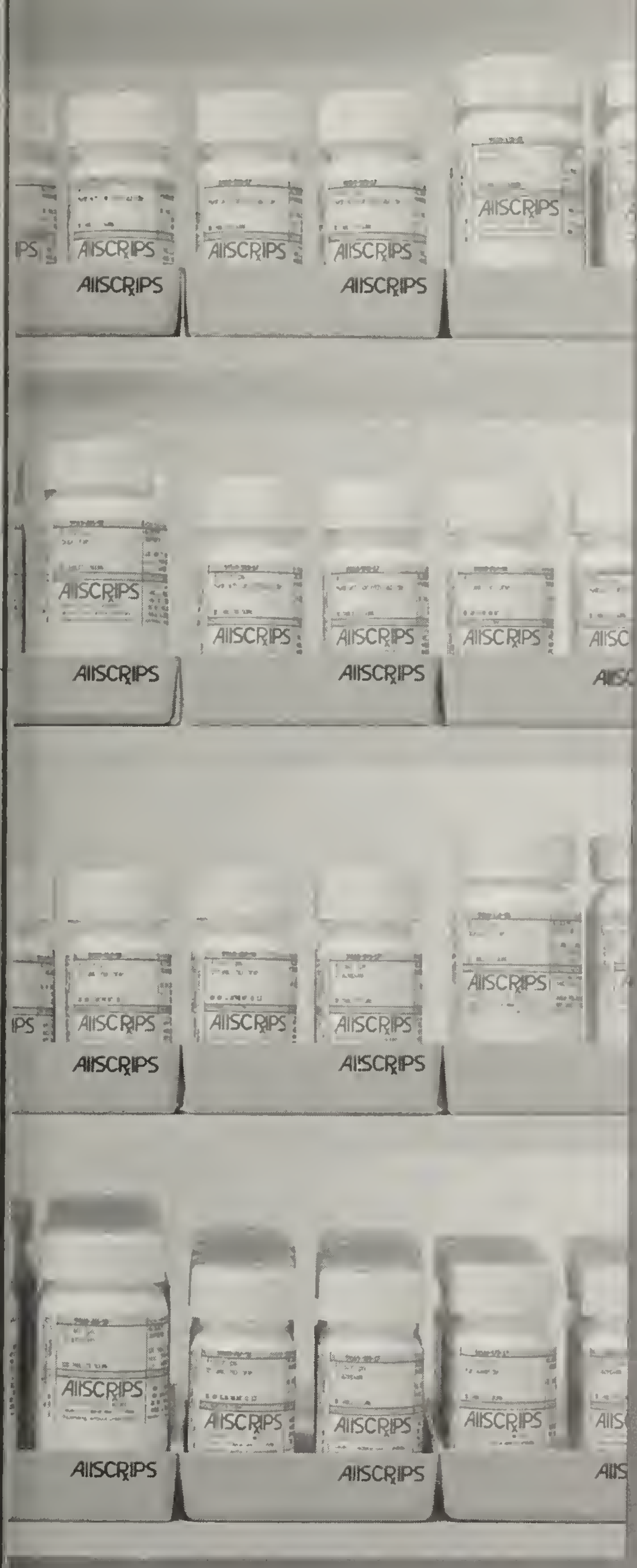

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MSMS holds news conference on Fleming's report

The Michigan State Medical Society April 1 called for a task force to find alternatives to tort reform for solving professional liability insurance problems.

Another round of medical liability insurance rate increases now taking effect have triggered the physicians' appeal, medical society spokesmen Carl A. Gagliardi, MD, and Robert E. Paxton, MD, told reporters at a Capitol news conference.

MSMS members feel the 1986 legislative package which brought about tort reform was just the beginning of what is needed, they said.

"The new rate increases buttress our appeal for a task force, which was recommended in December by the governor's factfinder, Robben Fleming," said Doctor Paxton.

"The rate increases reinforce our message that tort reform alone will not solve our professional liability problems," said Doctor Gagliardi, who also is chairman of the MSMS Task Force on Professional Liability.

The Michigan Physicians Mutual Liability company raised doctors' liability insurance premiums 15 percent across the board. The Physicians Insurance Company of Michigan followed suit within weeks.

"We say 'Amen' to Professor Fleming's recommendation for a task force to seek liability solutions other than tort reform," said Doctor Gagliardi. "We have not solved our problem nor concluded our work. We have just begun."☐

MSMS Chairman of the Board Robert Paxton, MD, makes a point to the media, above. Then-MSMS President-elect, Carl Gagliardi, MD, now president, answers questions, below.

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Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis especially for treatment of exertional or other stress-induced angina palpitations and syncope INDERAL LA also improves exercise performance The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation Clinical improvement may be temporary

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WARNINGS. CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure and its inhibition by beta blockade may precipitate more severe failure Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle

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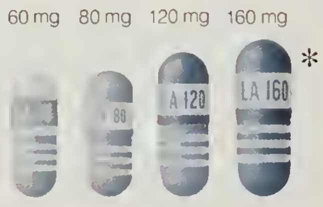
LONG ACTING CAPSULES



IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure Therefore, at the first sign or symptom of heart failure the patient should be digitalized and or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually if possible)

> IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial It should be noted however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents eg, dobutamine or isoproterenol However, such patients may be subject to protracted severe hypotension Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required Beta blockers may mask tachycardia occurring with hypoglycemia but other manifestations such as dizziness and sweating may not be significantly affected Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker In one case, this resulted after an initial dose of 5 mg propranolol

PRECAUTIONS. GENERAL Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure Patients should be told that INDERAL may interfere with the glaucoma screening test Withdrawal may le return of increased intraocular pressure

CLINICAL LABORATORY TESTS Elevated blood urea levels in patients with severe disease, elevated serum transaminase alkaline phosphatase lactate dehydrogenase

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as pine should be closely observed if INDERAL is administered The added catechol blocking action may produce an excessive reduction of resting sympathetic nervous which may result in hypotension, marked bradycardia vertigo, syncopal attacks or orth hypotension

Caution should be exercised when patients receiving a beta blocker are administ calcium-channel-blocking drug, especially intravenous verapamil, for both agents m press myocardial contractility or atrioventricular conduction On rare occasions, the co tant intravenous use of a beta blocker and verapamil has resulted in serious adverse rea especially in patients with severe cardiomyopathy, congestive heart failure or recent m dial infarction

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol

Ethanol slows the rate of absorption of propranolol

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance

Chlorpromazine, when used concomitantly with propranolol, results in increased p levels of both drugs

Antipyrine and *lidocaine* have reduced clearance when used concomitanl propranolol

Thyroxine may result in a lower than expected T_3 concentration when used concon with propranolol

Cimetidine decreases the hepatic metabolism of propranolol, delaying eliminatic increasing blood levels

Theophylline clearance is reduced when used concomitantly with propranolol

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY Long-term stu animals have been conducted to evaluate toxic effects and carcinogenic potential month studies in both rats and mice, employing doses up to 150 mg/kg/day, there v evidence of significant drug-induced toxicity There were no drug-related tumorigenic at any of the dosage levels Reproductive studies in animals did not show any impairr fertility that was attributable to the drug

PREGNANCY Pregnancy Category C INDERAL has been shown to be embryot animal studies at doses about 10 times greater than the maximum recommended humar

There are no adequate and well-controlled studies in pregnant women INDERAL shc used during pregnancy only if the potential benefit justifies the potential risk to the fetus

NURSING MOTHERS INDERAL is excreted in human milk Caution should be exe when INDERAL (propranolol HCl) is administered to a nursing woman

PEDIATRIC USE Safety and effectiveness in children have not been established

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have required the withdr[illegible]al of therapy

Cardiovascular Bradycardia congestive heart failure, intensification of AV block, hy sion, paresthesia of hands, thrombocytopenic purpura arterial insufficiency, usually Raynaud type

Central Nervous System. Light-headedness, mental depression manifested by ins lassitude weakness, fatigue, reversible mental depression progressing to catatonia disturbances, hallucinations, vivid dreams, an acute reversible syndrome characteri disorientation for time and place, sho memory loss, emotional lability, s clouded sensorium, and decreased mance on neuropsychometrics For imm formulations, fatigue, lethargy and dreams appear dose related

Gastrointestinal Nausea, vomiting, e tric distress, abdominal cramping, di constipation, mesenteric arterial thron ischemic colitis

Allergic Pharyngitis and agranuloc erythematous rash, fever combined wi ing and sore throat, laryngospasm and r tory distress

Respiratory Bronchospasm

Hematologic Agranulocytosis nonthrombocytopenic purpura, thrombocytopenic p

Auto-Immune In extremely rare instances, systemic lupus erythematosus ha reported

Miscellaneous Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impc and Peyronie's disease have been reported rarely Oculomucocutaneous reactions in the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) h been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochlor sustained-release capsule for administration once daily If patients are switched from IN Tablets to INDERAL LA Capsules, care should be taken to assure that the desired ther effect is maintained INDERAL LA should not be considered a simple mg-for-mg subst INDERAL INDERAL LA has different kinetics and produces lower blood levels. Retitrati be necessary, especially to maintain effectiveness at the end of the 24-hour dosing int

HYPERTENSION — *Dosage must be individualized* The usual initial dosage is INDERAL LA once daily, whether used alone or added to a diuretic The dosage r increased to 120 mg once daily or higher until adequate blood-pressure control is ac The usual maintenance dosage is 120 to 160 mg once daily In some instances a dosag mg may be required The time needed for full hypertensive response to a given do variable and may range from a few days to several weeks

ANGINA PECTORIS — *Dosage must be individualized* Starting with 80 mg INDEF once daily, dosage should be gradually increased at three- to seven-day intervals until response is obtained Although individual patients may respond at any dosage le average optimal dosage appears to be 160 mg once daily In angina pectoris, the va safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few wee WARNINGS)

MIGRAINE — *Dosage must be individualized* The initial oral dose is 80 mg INDEI once daily The usual effective dose range is 160-240 mg once daily The dosage increased gradually to achieve optimal migraine prophylaxis If a satisfactory respons obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy be discontinued It may be advisable to withdraw the drug gradually over a period of weeks

HYPERTROPHIC SUBAORTIC STENOSIS — 80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE — At this time the data on the use of the drug in this age group a limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratorie

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REFERENCES:

1. INDERAL LA National Compliance Evaluation Program Data on file, Ayerst Labora
2. Ravid M, Lang R, Jutrin I The relative antihypertensive potency of propranolol, oxp atenolol, and metoprolol given once daily *Arch Intern Med* 1985 145 1321-1323

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New MSMS President Gagliardi to continue liability battle

By Carole Eberly

Carl A. Gagliardi, MD, took the long route to becoming a physician. If World War II had not come along, he would most likely be an insurance executive today, and if he had finished his last year at MIT where he was working on a PhD in meteorology, he probably would be deciphering weather maps and charts.

Doctor Gagliardi, director of medical education at Oakwood Hospital, earned his undergraduate degree as a math major at Yale University, and was an intern during his junior and senior years at Metropolitan Insurance Company in New York. However, the Army had other plans for him and, since he was a math major, signed him for graduate school at MIT to study meteorology. He was sent to Puerto Rico to take courses in tropical forecasting.

"One day when I was ready to get out of the Army, I realized I always wanted to be a doctor," he recalled. "All of these other decisions up to that point had been made out of convenience. It was not what I wanted to do.

"So only one year away from getting my doctorate, I chucked it all and applied to medical school at Yale. I went around the circle."

Doctor Gagliardi is happy with his decision. He and his wife, Marjorie Stewart Gagliardi, MD, began a joint pediatric practice in 1953.

The author, Ms. Eberly, is a Lansing-area reelance writer.

But once he became involved in MSMS as a delegate in the 1950s, he realized how much of the care of patients was being taken out of the hands of physicians.

"We, as physicians must take a very active (political) role together to advocate the best medical care for our patients," he maintains. "You're a voice crying in the wilderness if you think you can do that alone. It became obvious to me that the only way we could have an influence, is to be not only our patients' physician, but their friend, their advocate."

He said his patients would sometimes call for family advice, even though he was a pediatrician. He felt flattered.

"Physicians can't surrender their role as advocates of patients," he added. "If we ever surrender that role, then we might as well go into some other field."

One of eight children

Perhaps some of his concern and ambition to protect quality care comes from his background. He was one of seven sons and one daughter born to parents who immigrated from Italy. He was not yet four years old when his father died, leaving his mother a widow to support the family.

"Mother hardly spoke English, but she absolutely worked her tail off to see that these eight kids went to school," he said proudly.

"You hate to see people work so hard, but there was great satisfaction when she saw her children and grandchildren all doing well. That kind of background is hard to minimize."

Doctor Gagliardi's brother, Raymond A. Gagliardi, MD, of Pontiac, recently was installed as president of the American Roentgen Ray Society.

A balance

Doctor Gagliardi seems to have found a balance between hard work and enjoyment of the little things that make life worth living. While sitting in a spacious glass-enclosed family room at his Dearborn home, he spotted a goldfinch at his bird feeder. He quickly made a mental note to fill the feeder, hoping to entice more feathered friends for the birds' mealtime.

And mealtime is something Doctor Gagliardi understands.

"When I quit medicine, I want to become a cook," he said, laughing at his hobby. "I love to cook. I read cookbooks often just for fun. Marge said I have to get a bigger box for my recipes.

However, as president of

Continued on next page

The Doctors Gagliardi

GAGLIARDI/Continued

MSMS, Doctor Gagliardi may be cooking up other things. He plans to "work night and day" on the liability problem. He is chairman of the MSMS Task Force on Professional Liability, putting in a tremendous number of hours during the last three years on the issue. He was the lead person in the physicians' rally in Lansing.

And although there were more physicians involved in that project than on any other, there was a certain letdown on the part of the participants.

"I don't think physicians will feel content until we see the spiral of increasing liability costs turned around and started downward," he predicted. "That's going to be my major job."

Doctor Gagliardi, who sees little of the money awarded in liability cases as going to the right persons in the right amounts, said the whole system is chasing physicians away from taking high risk cases.

"I keep pointing out that the infant mortality rate in some portions of Michigan is an absolute disgrace," he said. "If we could remove the risk for the high-risk physicians, they would march in there in droves to take care of those people."

Doctor Gagliardi suggested the state should set up a no-fault approach to babies born in the high-risk areas. He predicted the obstetricians, pediatricians and family practitioners would turn out in record numbers to take care of these patients.

"Let's try it," he said. "Let's look at something different for a change."

Other interests

Another area Doctor Gagliardi is interested in is working with impaired physicians.

"If you do become involved with those physicians early, the salvage rate is absolutely tremendous," he said. "It's a worthwhile thing to do."

As chairman of the steering committee to aid impaired physicians, his goal was to find a professional to take over the program and to work closer with the Board of Medicine to help people who need help.

"There are cases where a physician is ill," he said. "He's not a criminal. He's not incompetent. He has stress that has gotten him to do things none of us approve of. But he is salvageable.

"The Board of Medicine now more than ever realizes there is a place for moving them out of the criminal system and into the rehabilitative system."

The plan calls for the Board to turn an impaired physician over to the impaired physicians committee.

"We're perfectly willing to say that a patient who has diabetes should be willing to take the insulin he is asked to take," he continued. "So should the impaired physician take the kind of treatment he is being asked to take."

Doctor Gagliardi said he used the word "he" because the problem has been almost non-existent in female physicians.

"Whether that means women handle their stress better or it is simply a matter of numbers, I can't answer that," he said.

In addition, he said MSMS Auxiliary members, who are mostly female, have asked that the program be extended to include spouses who also need a support mechanism.

Also, Doctor Gagliardi sees the program extended to nurses, pharmacists, hospital administrators and other health professionals.

What does the would-be forecaster predict in the coming year?

"A lot of work," he said. ☐

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Hospital Medical Staff Section holds third annual meeting

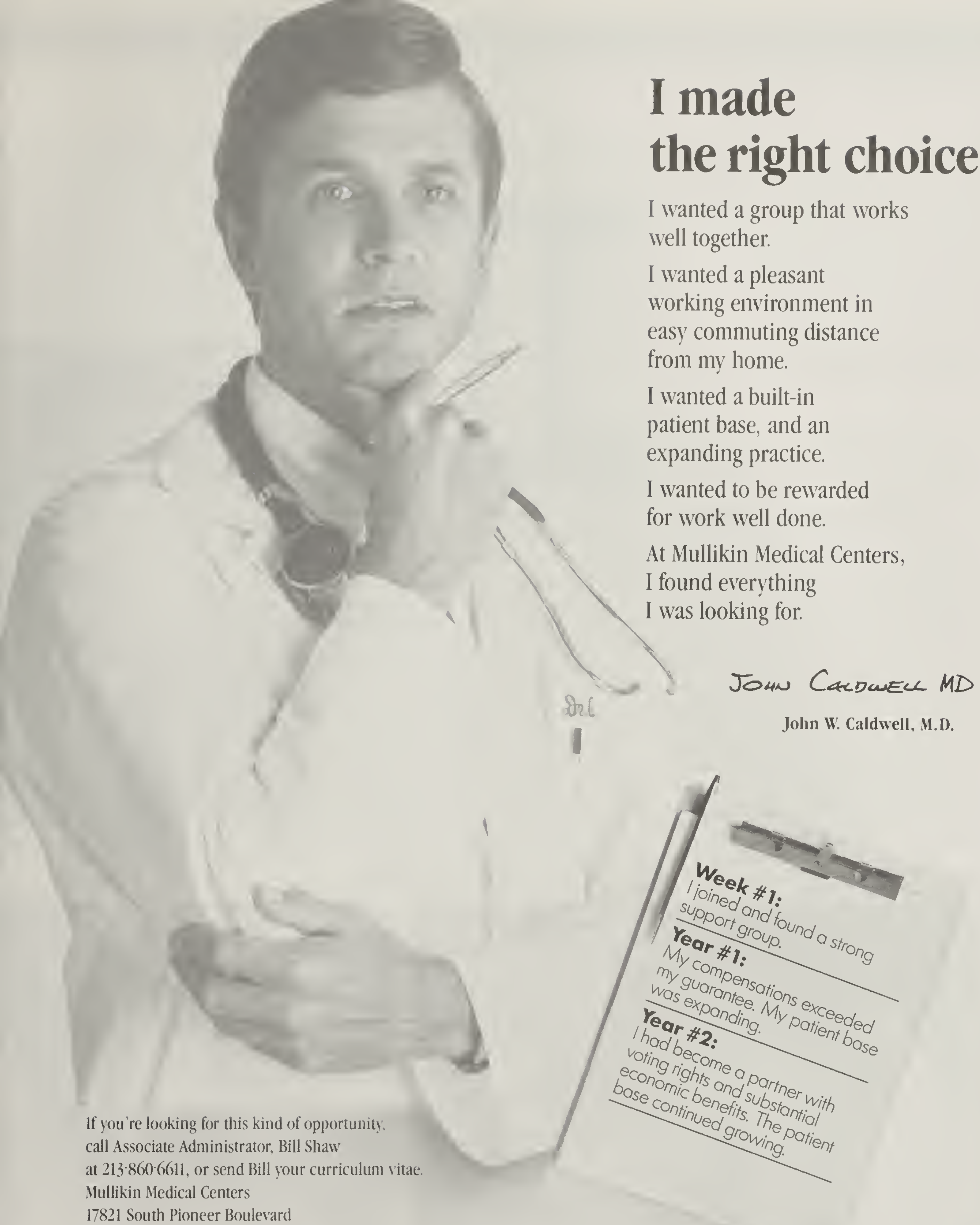
MEDICAL SOCIETY
MSMS

Peter Duhamel, MD, listens as Howard Lang, MD, chairman of the AMA-HMSS Governing Council, speaks.

The third Annual Meeting of the MSMS Hospital Medical Staff Section took place on Saturday, March 21, 1987 at the Hyatt Regency in Dearborn. A total of 66 HMSS representatives attended the day-long session. The delegates elected Gary Maynard, MD, Kalamazoo, as chairman of the section; Devandra Sharma, MD, Tawas City, as vice chairman; Gerhard Engler, MD, Detroit, as secretary for the Section, and Peter A. Duhamel, MD, Rochester, for an at-large position.

Thirteen resolutions were introduced at the meeting and 10 were approved as amended and submitted to the MSMS House of Delegates for further action. Five of the resolutions considered the peer review process and the Michigan Peer Review Organization (MPRO). Other resolutions dealt with model medical staff by-laws, funding for medical staff activities, a ban on alcoholic beverage advertising, establishing physician self-help groups and developing a statewide health care plan. Krishna K. Sawhney, MD, HMSS delegate to the House of Delegates, with the approval of the HMSS Governing Council, introduced two additional resolutions regarding Board of Licensing jurisdiction over physicians involved in chart review, and regarding legislation to allow the organized hospital medical staff to be a self-governing body. For

Continued on page 320



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details on House action on the resolutions, see your April 28 *Medigram*.

Luncheon speaker at the meeting was Howard Lang, MD, Chairman, AMA-HMSS Governing Council. Doctor Lang discussed the inherent powers of the medical staff. "The mission of the medical staff is to provide quality medical care using professional judgement and discretion," he said. "The economic responsibility (i.e. "mission") of the hospital board may at times come in conflict with patient care responsibilities, which are the rightful role of the medical staff. It is where these missions collide that the medical staff must be in the organizational position to take action consistent with the patients' best interest. That organizational mechanism is the self-governing medical staff."

Other speakers were Barbara Gagel, Regional Administrator HCFA Region V, Richard Burney, MD, president, MPRO, and Monte Jahnke, partner, Kerr Russell and Webber, MSMS legal counsel. The afternoon session revolved around a spirited discussion of the peer review process and, in particular, MPRO activities. ☐

MPRO President Richard Burney, MD, detailed peer review activites.

Michael Parks, MD, center, represented his hospital, South Haven Community.

HCFA Region V Administrator Barbara Gagel fielded ques tions.

III

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A day in the life of the MSMS Legislative Network

Grand Rapids physicians James Watkins, MD, center, and William Jensen, MD, right and his wife Beverly, met with their legislators at the Capitol in February. They met with Rep. Richard Bandstra in his office.

During lunch the physicians discussed liability reform with Rep. Bandstra, Rep. Ken Sikkema (foreground) and Sen. Dick Posthumus (center).

After lunch at the City Club in Lansing, the physicians and Mrs. Jensen, former legislative chairperson for the MSMS Auxiliary, observed a session of the Michigan House of Representatives. They met other West Michigan legislators there, including Rep. Rick Krause, Rep. Thomas Mathieu, Sen. Vern Ehlers, and Rep. Alvin Hoekman. For information on the Legislative Network, contact Dan Farhat at MSMS headquarters.

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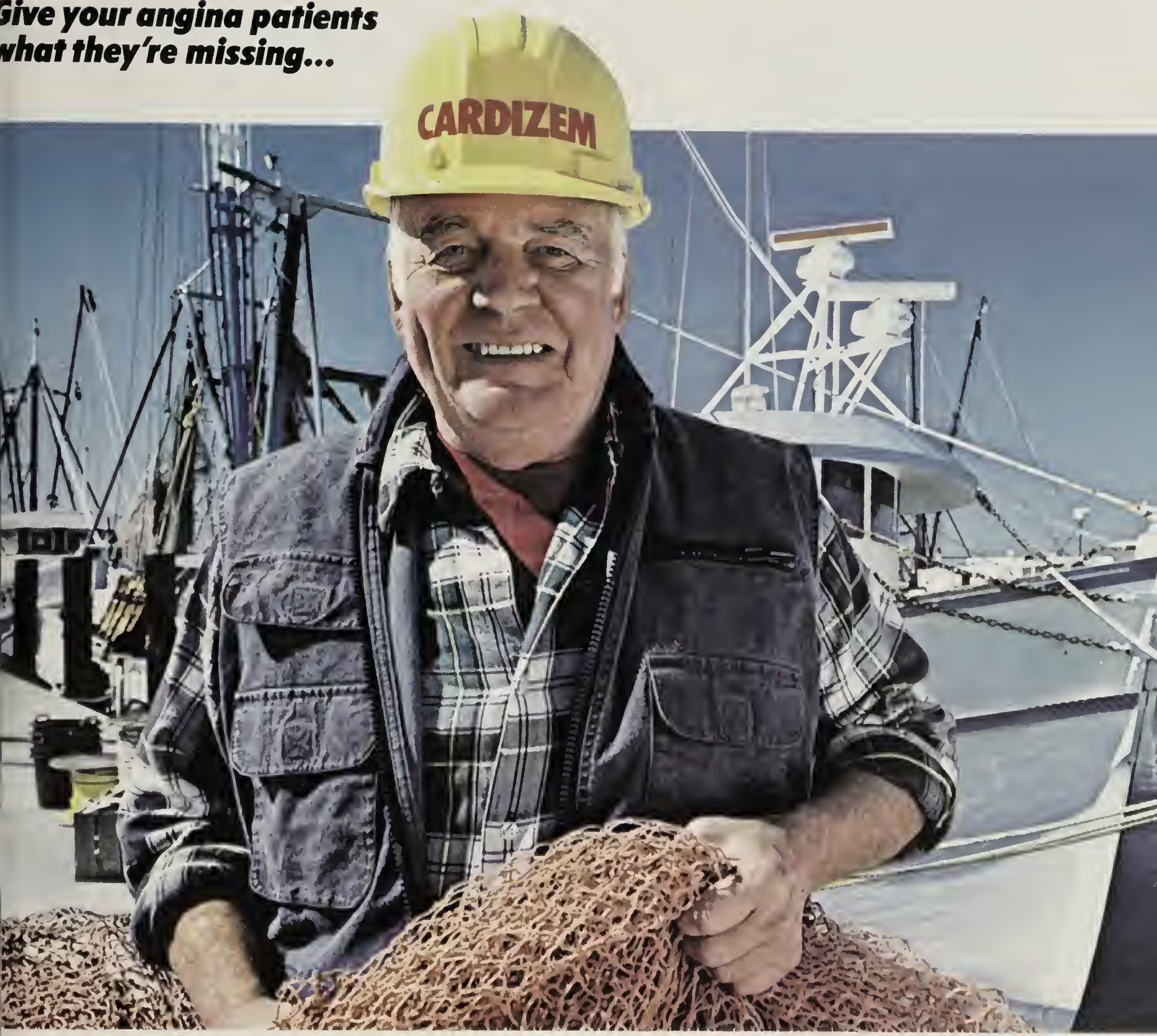

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Please see brief summary of prescribing information on the next page.

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Brief Summary
Professional Use Information

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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** *CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.*
2. **Congestive Heart Failure.** *Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).*
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** *Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.*
4. **Acute Hepatic Injury.** *In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)*

PRECAUTIONS

General. *CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.*

Drug Interaction. *Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)*

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. *A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.*

Pregnancy. *Category C. Reproduction studies have been conducted in mice, rats, and rabbits Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality These doses, in some studies, have been reported to cause skeletal abnormalities In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater*

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers. *Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted*

Pediatric Use. *Safety and effectiveness in children have not been established*

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1 5%), rash (1 3%), asthenia (1 2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular.	*Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.*
Nervous System:	*Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.*
Gastrointestinal.	*Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.*
Dermatologic.	*Petechiae, pruritus, photosensitivity, urticaria.*
Other:	*Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties*

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM. alopecia, gingival hyperplasia, erythema multiforme, and leukopenia However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. *Issued 7/86*

See complete Professional Use Information before prescribing

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University of Wisconsin Hospital and Clinics Announces the Directory for Referring Physicians

A new, comprehensive directory describing the complete range of services at UW Hospital and Clinics is now available.

The Directory for Referring Physicians contains information about each hospital department, specialty clinics, critical care and emergency transport services, as well as profiles of each UW Medical School faculty member. The Directory is a convenient source of information to help you reach more than 350 medical specialists at UW Hospital and Clinics.

Complementing the directory is our new toll-free MedCOM consultation line, designed to put you quickly in touch with the appropriate specialists for referral or consultation. Call us 24-hours a day at the numbers listed.

If you'd like a directory, please fill in the form and mail to: UW Hospital and Clinics, Room F6/242, 600 Highland Avenue, Madison, WI 53792.

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“Talking” computer verifies Blue Cross coverage

By Gayle Zelmer

Checking whether a patient has health care coverage from Blue Cross and Blue Shield of Michigan now is easier and quicker thanks to a “talking” computer.

CAREN, a Computer Assisted Response Environment Network operated by BCBSM, verifies the coverage of up to 20 different patients with one call. A touch-tone telephone is necessary to use the system.

CAREN operates from 7 am to 9 pm weekdays, and between 8 am and 9 pm Saturdays. In the metropolitan Detroit area the telephone number is (313)225-7614. The toll-free number for providers elsewhere in Michigan is 1-800-344-8525.

The system confirms whether or not a patient is covered by a current BCBSM contract. CAREN has information on subscribers with Blue Traditional or PPO coverage but not on members of BCBSM health maintenance organizations.

Questions about specific benefits or a specific situation should be directed to a BCBSM provider representative at (313)225-8211 (metropolitan Detroit area) or 1-800-482-3146 (toll free—remainder of Michigan).

For a free brochure about CAREN, contact a BCBSM provider representative.

While CAREN’s verification of subscriber eligibility does not guarantee payment by BCBSM, it expedites the checking of routine membership information. A “fast path” feature accelerates the process when more than one contract is being verified.

Before dialing CAREN, callers should have on hand each patient’s BCBSM contract number, year of birth and complete name. This information is entered or confirmed by pressing appropriate buttons on the telephone key pad.

If CAREN is out of service, a recording tells callers to try again later.

CAREN is part of BCBSM’s ongoing effort to improve service to health care providers in Michigan. ☐

The author, Ms. Zelmer, is supervisor, Provider Inquiry Department, Blue Cross Blue Shield of Michigan.

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Medicaid chief answers questions in Lansing and UP

Michigan's Medicaid chief, Kevin Seitz, has been making the rounds of county medical societies to answer questions and update members on reimbursement. To date he has visited half a dozen counties.

Seitz attended a breakfast meeting with the Ingham County Medical Society's legislative committee in Lansing.

Chairman of Ingham County's legislative committee, Mitch Rinek, MD, asks for clarification.

Seitz left Lansing and met with Upper Peninsula physicians the next day in L'Anse. MSMS Director Ken Rowe, MD, is at far left, with David Gilbert, MD, president of the Marquette/Alger County Medical Society, at center.

Doctor Rowe, left foreground, joined other physicians in listening to Seitz's presentation. They include: William Sarazin, MD, left, Wayne Charland, MD, seated at back, and Scott Pynnonen, MD, right foreground.

A primer on making progress at the Capitol

By Larry Glazer

This article is taken from comments made by Mr. Glazer, legal advisor to Governor Blanchard, at a recent MSMS Critical Issues Forum in Kalamazoo.

> **"From time to time you will see a movement sweep through the capitol, and action will be taken fairly quickly."**

There are certain generalizations one can make about the process of the enactment of new laws and of getting what you want, or keeping the other side from getting what they want. Now this probably won't be new to you, but the perspective is something you haven't heard before. Basically there are three branches of government, the judicial, the executive and the legislative. That's true constitutionally, but I will dwell on what I call the "active" side of government.

The judiciary generally waits until a dispute arises and is brought to court by someone else and then makes a decision on that particular case. The other parts of government are more proactive. They go out and try to make things happen. They respond to all kinds of signals, all kinds of constituents. Let's look at the executive branch, which is the governor, his advisors, and the departments of government.

Whenever an issue is hot in Lansing, you will probably find one or more of the governor's advisors, and one or more of the departments involved. Civil service, department heads and deputies talk to us advisors and the governor—all of them try to figure out what position to take.

Then there's the legislature, which consists of several hundred individuals. On any given topic, they are most interested in the people who are chairing each particular committee and in the viewpoint of the speaker of the House and the majority leader in the Senate.

The interests

Then we get into what I call the "interests." Interests is a term almost always used pejoratively in public speeches and in the media, but I don't think most of us in Lansing really think of interests in that way. An interest is anybody, institutional usually, representing large numbers of individuals, organized to present points of view to the rest of us in government. Obviously the hospital association is an interest, the medical society is an interest, the osteopathic association is an interest. There are many overlapping interests and overlapping viewpoints.

Then finally, you see the media and the people. The media may expose something and get a lot of the people interested in it. They may take it to the point where it commands the attention of the other branches of government, including interests, the executive and the legislature.

At the same time, all these groups talk to each other—we are constantly in contact. The interests talk to key legislators and to the governor's advisors. Then we talk to the interests, we talk to the legislators, and we talk to the media. Then the media comes to us and asks us a lot of questions.

From time to time you will see a movement sweep through the capital, and action will be taken fairly quickly. An example would be the emergency prison construction program we initiated at the end of 1984. There was such broad agreement and so little disagreement among any of the government groups, we were able to construct over 3,000 new cells in one year. That's what happens when there is broad agreement among two or three of those groups and no meaningful opposition from any of the others.

Closer to home

On the other hand (I'm going to hit a little closer to home) we can encounter situations where there is tremendous disagreement. Such was the case last year

Continued on page 332

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when dealing with the question of liability reform, in particular, malpractice liability reform. That issue first came to public attention when 10,000 persons, mostly physicians, came to the front lawn of the capital and in an orderly way addressed the legislature with their concerns. I think that got the media interested in it. The media started looking around and found that indeed this was a problem for an awful lot of physicians in the state and they started getting the stories out.

They got the attention of those who were perfectly happy with the present system and didn't want it changed: for example, plantiff's trial attorneys. They began communicating *their* side to the media, to the legislature and to us in the executive office. Finally after months and months of very hard work by all parties, we just barely were able to enact a series of reforms.

I know how close they were to not being enacted—very, very close to nothing happening at all. What finally was enacted was a compromise which didn't satisfy very many people, including the governor, but it did at least make some significant changes in the liability laws.

I think everyone recognizes that more has to be done in the future. We did not go far enough, we have to do more and we relied on Robben Fleming to make a detailed investigation of this and come up with recommendations. Doctor Fleming and I agreed that we had never seen an issue which got people so entrenched so early which resulted in compromise down the line.

"Mr. Brummer's water bed helped his back — but he's suing you for causing he and his wife to drift apart."

Achieving change

In order to achieve change, in order to address your needs, you have to get the broad government into agreement (or at least two or three parts of it into agreement) without significant opposition from the other parts. If you don't do that, not much is going to happen. Therefore, we have to stay in communication—we have to listen to you, you have to listen to us. We all have to be willing to compromise even though we don't want to.

The choice is this: compromise and some achievement or entrenchment and no achievement. It has been my experience that your leadership is very able in communicating their needs to us and in understanding how the process works. Everything happens for a reason, and there are reasons when the legislature and other parts of government don't respond. The people you have retained, hired and elected to represent you in Lansing can tell you those reasons. Listen to them because generally they give good advice. ☐

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130
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In mild to moderate hypertension

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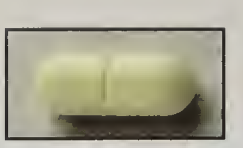

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JAMES B.
38, black male, heavy smoker. Prescribed a diuretic by another physician last year for hypertension.

YOUR CONCERNS
Presents with "smoker's cough." Workup reveals a BP of 150/107.

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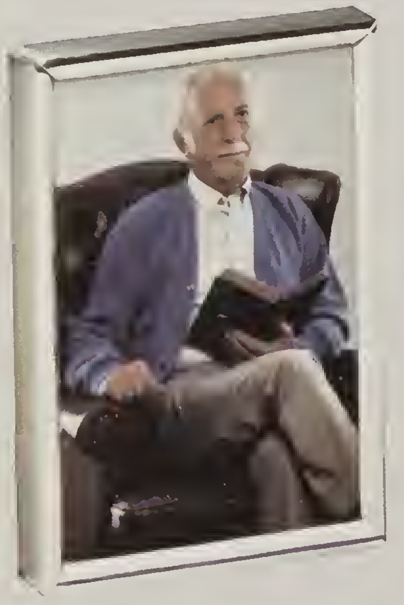
ISOPTIN* (verapamil HCl/Knoll) because...
— Black hypertensives often have low plasma renin activity and generally do not respond favorably to beta blockers.
— Beta blockers may increase the likelihood of bronchospasm.

ALICE W.
65, diabetic, overweight. Her BP has elevated to 190/98.

YOUR CONCERNS
She's on daily insulin.

A LOGICAL CHOICE FOR CONTROL OF HER BP
ISOPTIN* (verapamil HCl/Knoll) because...
— Unlike most beta blockers and diuretics, ISOPTIN has no adverse effects on serum glucose levels.
— Unlike most beta blockers, ISOPTIN does not mask the symptoms of hypoglycemia.



THOMAS G.
70, asthmatic. In the past, BP adequately controlled with 25 mg hydrochlorothiazide daily.

YOUR CONCERNS
Today patient presents with symptoms of gout. Workup reveals high uric acid level, low serum potassium, and BP elevated to 180/98.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
ISOPTIN* (verapamil HCl/Knoll) because...
— Unlike diuretics, ISOPTIN will not decrease serum potassium levels or elevate uric acid levels.
— Unlike beta blockers, ISOPTIN can be used safely in asthma and COPD patients.

JOHN K.
42, Annual physical uncovered diastolic BP of 102... confirmed on three successive office visits. Unresponsive to nonpharmacologic intervention.

YOUR CONCERNS
Salesman, spends many hours of his working day in car... total cholesterol level 300, HDL 35.

A LOGICAL CHOICE FOR CONTROL OF HIS BP
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— Unlike diuretics, ISOPTIN does not cause urinary urgency.
— Unlike either beta blockers or diuretics, ISOPTIN will not adversely affect his already seriously compromised lipid profile.
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Brief Summary

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CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome or 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker).

WARNINGS: Heart Failure: ISOPTIN should be avoided in patients with severe left ventricular dysfunction (see DRUG INTERACTIONS). Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. Hypotension: ISOPTIN (verapamil HCl) may produce occasional symptomatic hypotension. Elevated Liver Enzymes: Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. Accessory Bypass Tract (Wolff-Parkinson-White): Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway have developed increased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk. Treatment is usually D.C.-cardioversion. Atrioventricular Block: The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare instances, discontinuation of verapamil HCl. Patients with Hypertrophic Cardiomyopathy (IHSS): Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIDNS: Impaired Hepatic or Renal Function: Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted in the urine. In patients with impaired hepatic or renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see OVERDOSAGE).

Drug Interactions: Beta Blockers: Concomitant use of ISOPTIN and oral beta-adrenergic blocking agents may be beneficial in certain patients with chronic stable angina or hypertension, but available information is not sufficient to predict with confidence the effects of concurrent treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities. Digitalis: Clinical use of verapamil in digitalized patients has shown the combination to be well tolerated if digoxin doses are properly adjusted However, chronic verapamil treatment increases serum digoxin levels by 50 to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISOPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. Antihypertensive Agents: Verapamil administered concomitantly with oral antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, diuretics, beta blockers, prazosin) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored. Disopyramide: Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. Quinidine: In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine resulted in significant hypotension. There has been a report of increased quinidine levels during verapamil therapy. Nitrates: The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. Cimetidine: Two clinical trials have shown a lack of significant verapamil interaction with cimetidine. A third study showed cimetidine reduced verapamil clearance and increased elimination to 1/2. Anesthetic Agents: Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. Carbamazepine: Verapamil may increase carbamazepine concentrations during combined therapy. Rifampin: Therapy with rifampin may markedly reduce oral verapamil bioavailability. Lithium: Verapamil may lower lithium levels in patient on chronic oral lithium therapy. Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test Studies in female rats did not show impaired fertility. Effects on male fertility have not been determined. Pregnancy (Category C): There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery. This drug should be used during pregnancy, labor, and delivery, only if clearly needed. Nursing Mothers: ISOPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. Pediatric Use: Safety and efficacy of ISOPTIN in children below the age of 18 years have not been established.

ADVERSE REACTIONS: Constipation 8.4%, dizziness 3.5%, nausea 2.7%, hypotension 2.5%, dema 2.1%, headache 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, bradycardia 1.4%, 1° AV block 0.8%, flushing 0.1%, elevated liver enzymes (see WARNINGS). The following eactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the hysician to a possible relationship: angina pectoris, arthralgia and rash, AV block, blurred ision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, yspnea, ecchymosis or bruising, equilibrium disorders, exanthema, gastrointestinal distress, ingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, nsomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic ymptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, sweating, yncope, urticaria. Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe ypotension or complete AV block occur following oral administration of verapamil, the ppropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium luconate (10% solution). If further support is necessary, inotropic agents (dopamine or obutamine) may be administered. Actual treatment and dosage should depend on the severity nd the clinical situation and the judgment and experience of the treating physician.

VERDOSAGE: Treatment of overdosage should be supportive. Beta-adrenergic stimulation or arenteral administration of calcium solutions may increase calcium ion flux across the slow hannel, and have been used effectively in treatment of deliberate overdosage with verapamil. linically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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AIDS programs available from MSMS

By Sheri W. Greenhoe, Managing Editor

The Michigan State Medical Society AIDS Speakers Bureau offers educational programs on AIDS health care issues—at no charge—to health professionals throughout the state. The programs are presented by speakers who are experts in infectious disease and infection control.

Speakers are available to address a variety of issues, including the origins of AIDS; epidemiology; ethical/legal concerns; psychosocial aspects of AIDS; transmission of the AIDS virus and AIDS testing.

More than 20 programs already are scheduled for groups including nurses, hospital medical staffs, HMO staffs, nursing home employees, optometrists and third party administrators. While programs are tailored to individual groups depending on their preferences and expertise, infection control, counseling and testing are key topics addressed by the speakers.

The MSMS AIDS Speakers Bureau is a part of the AIDS Provider Education Plan, a plan devised by the AIDS Provider Education Task Force. The task force was formed when the Michigan legislature appropriated $250,000 to the Michigan Department of Public Health to implement recommendations of the Governor's Expert Committee on AIDS. The MDPH, in turn, contracted with MSMS to design a plan to educate physicians and other health care professionals. Frederick W. Bryant, MD, Royal Oak, chaired the task force of 38 persons including health care providers, health facility personnel, advocacy groups and public health leaders. Mary Ann Ford, MSMS chief of government relations, staffed the committee.

Sixty speakers—infectious disease specialists, infection control practitioners and medical ethicists—are prepared to address interested health care groups. Infection control guidelines and other materials are distributed during their presentations, which in some instances qualify as Category I CME credit.

Health care professionals interested in scheduling an AIDS presentation through the speakers bureau should contact Rose Heald at MSMS headquarters, (517)337-1351. ☐

Controlled substance license renewal system improved

By Thomas J. DeKornfeld, MD

This license is required for writing a prescription for any drug defined as a controlled substance and included in the amended "schedules" One to Five.

Since a number of disciplinary actions before the Board involve controlled substances, and since there are some procedural changes in the renewal of the controlled substance license, it is timely to discuss this matter.

First, let's clear up a source of confusion. The Board of Pharmacy issues two distinct licenses to physicians and other health care providers, which have the word "control" in their title. There is the "drug control license" which is required to dispense any prescription drug, and there is the "controlled substance license" which is specifically related to prescribing controlled substances.

The drug control license is defined in the Public Health Code under section 333.17745 as follows:

"A prescriber who wishes to dispense drugs shall obtain from the Board (Board of Pharmacy) a drug control license for his or her principal place of practice. A drug control license is not necessary if the dispensing involves only the issuance of complimentary starter dose drugs."

The license is required for all physicians who wish to dispense any prescription drug directly to their patient. It is renewed at the same time as the professional license. At the present time the triennial fee is $45. Holding such a license enables the physician to order and keep prescription drugs in his/her office and to dispense them directly to the patient. This may have some advantages both to the physician and to the patient.

Holding such a license, however, also imposes a number of obligations on the physician, which in many respects are quite similar to the duties imposed on the pharmacies. Ordering, storing, record keeping and labeling of drugs is regulated by the Public Health Code and by the rules promulgated by the Board of Pharmacy. Space does not allow consideration of these regulatory requirements, but I cannot emphasize too strongly the obligation every physician has to become thoroughly familiar with these rules prior to dispensing medications. As you know, ignorance of the law is not an excuse if the complex rules governing the dispensing of drugs are violated.

The "controlled substance license" is a very different matter. This license is required for writing a prescription for any drug defined as a controlled substance and included in the amended "schedules" One to Five. Actually, even a controlled substance license does not authorize the prescribing of substances in Schedule One. These substances require a separate and distinct federal license issued only to recognized clinical pharmacologists.

Schedules Two through Five include the CNS depressant and stimulating drugs, which may lead to chemical dependence or which are considered to be sufficiently hazardous to warrant special regulatory consideration. The list is long but should be immediately available for reference to all physicians.

The rules are particularly stringent for Schedule Two drugs. These are the opiates in therapeutic doses, most of the synthetic narcotics, cocaine, the amphetamines and most barbiturates. Prescriptions for these drugs are not renewable and the amphetamines require a special waiver from the Board of Medicine before they may be prescribed.

Prescriptions for drugs in Schedules Three and Four can be refilled only five times or over a six month period, whichever comes first. Schedule Five drugs can be refilled any number of times but the prescription must so indicate.

Continued on page 340

The author, Doctor DeKornfeld, is administrator, Michigan Board of Medicine.

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LICENSE/Continued

Other features

There are many other features to these rules governing such matters as the information that must be contained on the prescription, and the issuance of such prescriptions to known or suspected chemically dependent patients. As above, all physicians must become familiar with the requirements of the Public Health Code and/or the rules. Mistakes can lead to very serious consequences.

In the past the controlled substance license was issued for one year only, independent of the professional license. The renewal date for the controlled license was in June, while the professional license came due in January. This has led to confusion and imposed a considerable and avoidable burden on both the practitioner and on the Bureau of Health Services.

Effective this summer, the renewal of the controlled substance license will be synchronized with the professional license. Consequently the controlled substance license, issued this July, will be co-terminous with the professional license. In other words, if your professional license expires on January 31, 1988, your controlled substance license, issued in July, 1987, will be valid for seven months only. When you then renew your professional license in January for three years, the controlled substance license also will be renewed for three years.

If your professional license expires in January, 1989, you will receive a controlled substance license this July for 19 months and if your professional license is valid until January, 1990, then your controlled substance license that you get this July will be valid until that same date, i.e. for 31 months.

"The new computer is going to fit in great around here. It's starting to spread rumors."

Renewal fees

The renewal fees for your controlled substance license this July will accordingly depend upon the number of months that it will remain in effect. In other words, when your professional license expires. The controlled substance renewal fee is calculated on the basis of $2.50 per month. On this basis, your bill would be $17.50 for seven months, $47.50 for 19 months, and $77.50 for 31 months. These fees will, of course be in addition to your regular professional license fee, which is currently $120.00 for three years.

After this renewal cycle everybody will pay the same amount, i.e. three years worth of professional license fee renewal and three years worth of controlled substance license fee.

If you do not prescribe, administer or dispense any controlled substance, you do not need a controlled substance license. If, however you do want to prescribe, administer, or dispense any of these substances you do need a Michigan controlled substance license, in addition to the Federal Drug Enforcement Administration (DEA) license.

One final reminder. If you have more than one location where you prescribe controlled substances, you must have a Michigan controlled substance license for each. ☐

Board of Medicine actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are reproduced verbatim from summaries prepared by the Michigan Department of Licensing and Regulation.

Name: Ryan Krebs, MD
Action, Date Taken: License Revoked, Feb. 19, 1987
Reason: Criminal conviction/conspiracy to possess with intent to distribute and to distribute controlled substances.

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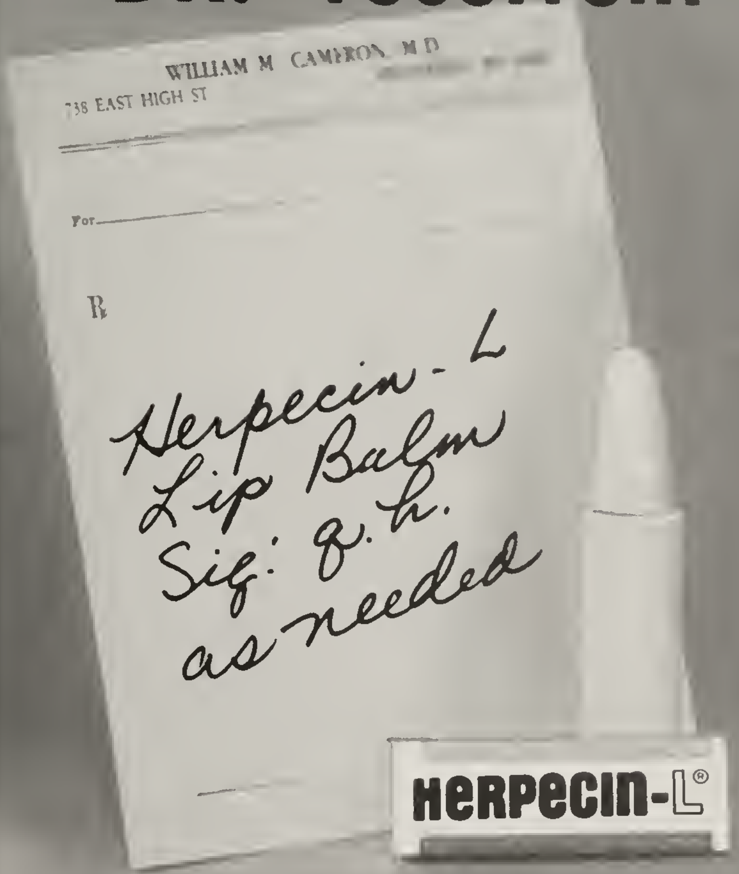

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Reyes Syndrome winter summary

Since October 1, 1986 one case of Reye's Syndrome has been reported in Michigan. This was a three year old male from Macomb County who died in November.

The year's influenza season was dominated by Type A (H1N1) viruses. Influenza A/Taiwan/86-like viruses represented 99 percent of the more than 2,000 isolates reported. Influenza B virus was isolated from sporadic cases in California, North Carolina, Texas, Washington and Wyoming. Type A (H3N2) virus was isolated from sporadic cases in Alaska, Arizona, Colorado, Texas and Wyoming.

In Michigan, Taiwan-like type A virus was isolated from Berrien, Charlevoix, Houghton, Kent, Washtenaw and Wayne counties. Widespread influenza-like illness was reported in schools in Berrien, Washtenaw and Wayne counties.

Publication on drivers

The AMA has just introduced a new publication, "Medical Conditions Affecting Drivers," that was prepared under the auspices of the Council on Scientific Affairs. It replaces the former AMA booklet, "Physician's Guide for Determining Driver Limitation," that had been a primary publication in the field since the early 1960s.

"Medical Conditions Affecting Driving" was written and edited by members of AMA's scientific staff, in cooperation with an expert committee of 18 physicians and non-physicians. The project took three years to complete. Prepared principally for physicians, the 86-page volume considers physician responsibilities associated with driving vehicles.

Topics discussed include effects of alcohol and other drugs on driving, prevention of vehicle-related injuries and guidelines relating to diabetes, epilepsy, coronary artery disease, visual problems, musculoskeletal abnormalities, psychiatric conditions and other abnormalities.

Cost per copy is $15 for AMA members and $35.50 for all others. To order copies write AMA's Order Department, PO Box 10946, Chicago, IL 60610, indicating that you want the AMA publication OP-018. Orders also may be placed by calling AMA's toll-free number (1-800-621-8335) which is restricted to VISA and Mastercard orders.

Brain mapping charts stroke

People who suffer from stroke, seizures due to epilepsy and migraines are undergoing a new method of diagnosis at Henry Ford Hospital that highlights the affected region of the brain using a sophisticated computerized system known as brain mapping.

The non-invasive study has been used to assess more than 90

Continued on page 346

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Keflet is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

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Brief Summary. Consult the package literature for prescribing informatic
Indications and Usage: Keflet™ Tablets (cephalexin, Dista) are indicate for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Respiratory tract infections caused by *Streptococcus pneumoniae* and group A β-hemolytic streptococci (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. Keflet is generally effective in the eradication of streptococci from the nasopharynx, howev substantial data establishing the efficacy of Keflet in the subsequent prevention of rheumatic fever are not available at present.)
Otitis media due to *S pneumoniae*, *Haemophilus influenzae*, staphylococci, streptococci, and *Neisseria catarrhalis*
Skin and skin-structure infections caused by staphylococci and/or streptococci
Bone infections caused by staphylococci and/or *Proteus mirabilis*
Genitourinary tract infections, including acute prostatitis, caused by *Escherichia coli*, *P mirabilis*, and *Klebsiella* sp.

Note—Culture and susceptibility tests should be initiated prior to and during therapy Renal function studies should be performed when indicate
Contraindication: Keflet is contraindicated in patients with known allerg to the cephalosporin group of antibiotics
Warnings: BEFORE CEPHALEXIN THERAPY IS INSTITUTED CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN SENSITIVE PATIENTS

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously No exception should be made with regard to Keflet

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.
Precautions: *General*—Patients should be followed carefully so that any side effects or unusual manifestations of drug idiosyncrasy may be detected If an allergic reaction to Keflet occurs, the drug should be discontinued and the patient treated with the usual agents (eg, epinephrine or other pressor amines, antihistamines, or corticosteroids).

Prolonged use of Keflet may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Keflet should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

Indicated surgical procedures should be performed in conjunction with antibiotic therapy

As a result of administration of Keflet, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—The daily oral administration of cephalexin to rats in doses of 250 or 500 mg/kg prior to and during pregnancy, or to rats and mice during the period of organogenesis only, had no adverse effect on fertility, fetal viability, fetal weight, or litter size. Note that the safety of cephalexin during pregnancy in humans has not been established

Cephalexin showed no enhanced toxicity in weanling and newborn rats as compared with adult animals. Nevertheless, because the studies in humans cannot rule out the possibility of harm, Keflet should be used during pregnancy only if clearly needed

Nursing Mothers— The excretion of cephalexin in the milk increased up to 4 hours after a 500-mg dose, the drug reached a maximum level of 4μg/mL then decreased gradually, and had disappeared 8 hours after administration Caution should be exercised when Keflet is administered to a nursing woman
Adverse Reactions: *Gastrointestinal*—Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely The most frequent side effect has been diarrhea It was very rarely severe enough to warrant cessation of therapy Dyspepsia and abdominal pain have also occurred As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.

Hypersensitivity— Allergic reactions in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson Syndrome, or toxic epidermal necrolysis have been observed. These reactions usually subsided upon discontinuation of the drug. Anaphylaxis has also been reported

Other reactions have included genital and anal pruritus, genital moniliasis, vaginitis and vaginal discharge, dizziness, fatigue, and headache. Eosinophilia, neutropenia, thrombocytopenia, and slight elevations in SGOT and SGPT have been reported

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Additional information available to the profession on request from

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NEWSFRONTS/Continued

patients since it was installed last June. The brain mapping system is of the first in the state being used for clinical evaluations and research, according to K.M.A. Welch, MD, director of the hospital's stroke center and chairman of the department of neurology.

Brain mapping records brain waves as does an EEG, but goes a step beyond by transforming the electrical pattern into a computerized printout. Simultaneously, four-color images of the brain appear on the computer screen allowing physicians to correlate the EEG with the affected region of the brain. The image may reveal abnormalities not readily evident on the brain wave pattern.

During the procedure, the patient's brain waves are monitored by electrodes. A complete diagnostic test may take up to one and a half hours. Brain wave activity is recorded while the patient is awake, then asleep.

"The unit provides a sensitive measure of brain activity and may reveal subtle differences in the brain wave patterns not evident in the EEG," according to Doctor Welch. "Brain mapping may detect strokes caused in the deeper regions of the brain which cannot be seen by other methods."

Brain mapping also is used extensively in the hospital's adult epilepsy clinic to determine the site and extent of seizures. Such seizures may be caused by stroke, damage to the central nervous

Continued on page 350

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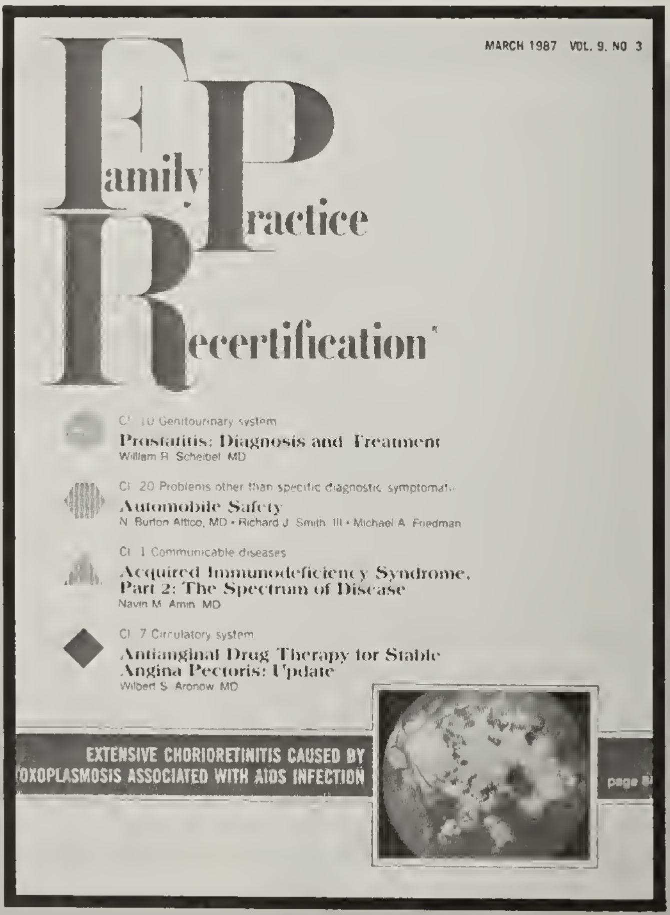

MARCH 1987 VOL. 9, NO 3

Family Practice Recertification*

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Prostatitis: Diagnosis and Treatment
William R Scheibel MD

CI 20 Problems other than specific diagnostic symptomat
Automobile Safety
N Burton Attico, MD • Richard J Smith III • Michael A Friedman

CI 1 Communicable diseases
Acquired Immunodeficiency Syndrome, Part 2: The Spectrum of Disease
Navin M Amin MD

CI 7 Circulatory system
Antianginal Drug Therapy for Stable Angina Pectoris: Update
Wilbert S Aronow MD

EXTENSIVE CHORIORETINITIS CAUSED BY OXOPLASMOSIS ASSOCIATED WITH AIDS INFECTION

page 8

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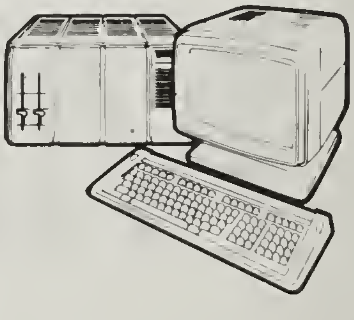

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NEWSFRONTS/Continued

system or other factors. Results can help the physician develop a treatment plan and monitor the patient's progress, according to Clinic Director Robert Simkins, DO.

Microselection allows safer radiation

Beaumont Hospital's Radiation Oncology Department has designed a technique to treat large malignant pelvic tumors with brachytherapy while eliminating radiation exposure to medical personnel.

The technique combines the use of interstitial template brachytherapy and remote afterloading of the radioactive materials used in the brachytherapy process.

The template being used at Beaumont was developed by Alvaro Martinez, MD, director of radiation oncology. Called the MUPIT (Martinez Universal Perineal Interstitial Template), the plastic device receives hollow needles which carry radioactive materials directly into the patient's tumor.

Radioactive sources, previously loaded into the needles by hand and left in place for the duration of the brachytherapy treatment, are now stored in the lead-lined microselectron which is hooked up to the MUPIT. When the microselectron is activated from a panel outside the treatment room, radioactive materials travel through the machine's vacuum-like tubes and into the needles. The materials can be drawn back into the microselectron whenever personnel enter the room to care for the patient, thus eliminating any exposure to radiation.

Camp for asthmatic kids

The Michigan Allergy Society invites you to volunteer three days of your time at Camp Michi-MAC this July. And, please tell your asthmatic patients about camp and urge them to apply.

Now into its fifth year, Camp Michi-MAC gives the asthmatic child a "normal" active camping experience charged with fun and excitement. Volunteer camp staff including physicians, nurses, respiratory therapists and pharmacists give the necessary medical support.

This year's camp will be held at YMCA Storer Camps on beautiful Stony Lake in Jackson.

There will be two six-day sessions, July 19 through 24 or July 25 through 31 for grades two through five. Twelve day sessions from July 19-31 are being offered to children entering grades six through 11.

For a six day session the charge per camper is $240. The 12-day camper will pay $450. Camperships (like scholarships) are available from the American Lung Association of Michigan.

Call either David Seaman, MD, at (313)453-2661 or Allen Sosin, MD, at (313)478-6303 to volunteer or for information and applications for Camp Michi-MAC. □

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Carl C. Beckwith, MD
Detroit

Doctor Beckwith, a general practitioner in the Detroit area for forty years, died November 5, 1986. He received his medical degree from Howard University, and was on the staffs of Burton Mercy and Brent hospitals. Doctor Beckwith served in the US Navy in World War II, and in the Naval Reserves in the Korean War. He was a member of Kappa Pi Fraternity, the Wayne County Medical Society and the American Academy of General Practitioners.

George E. Dimond, MD
Birmingham

Doctor Dimond died March 2 at the age of 67. He received his medical degree from Northwestern University Medical School in 1944. Doctor Dimond served as a captain in the US Army in World War II, and helped found the Oakwood Hospital in Dearborn. He retired from his Dearborn practice two years ago after 30 years of service.

Francis Alan Kennedy, MD
Coloma

Doctor Kennedy died April 1 at the age of 69. He received his medical degree from the University of Vermont in 1941. Doctor Kennedy was a captain in the US Army in World War II. He was a delegate to MSMS from 1966 to 1983, and former president of the Berrien County Medical Society. Doctor Kennedy was retired from practice and from the staff of Mercy Hospital, Benton Harbor, and St. Joseph Hospital, St. Joseph.

Raymond F. Lipton, MD
Franklin

Doctor Lipton died March 3 at the age of 73. He received his medical degree from Wayne State University in 1937 and specialized in surgery and industrial practice. He served as a medical military officer from 1941 to 1946 and was affiliated with Grace Hospital in Detroit. He was a member of the Detroit Surgical Society and the Wayne County Medical Society.

Maxim P. Melnik, MD
Detroit

Doctor Melnik died January 23 at the age of 79. A general surgeon in the Detroit area for forty years, he received his medical degree at Wayne State University School of Medicine where he was also a clinical instructor. He was the author of *Short Road to Health* and contributed to professional medical journals. Doctor Melnik was on the staffs of Detroit Receiving, Crittenton and Alexander Blain hospitals.

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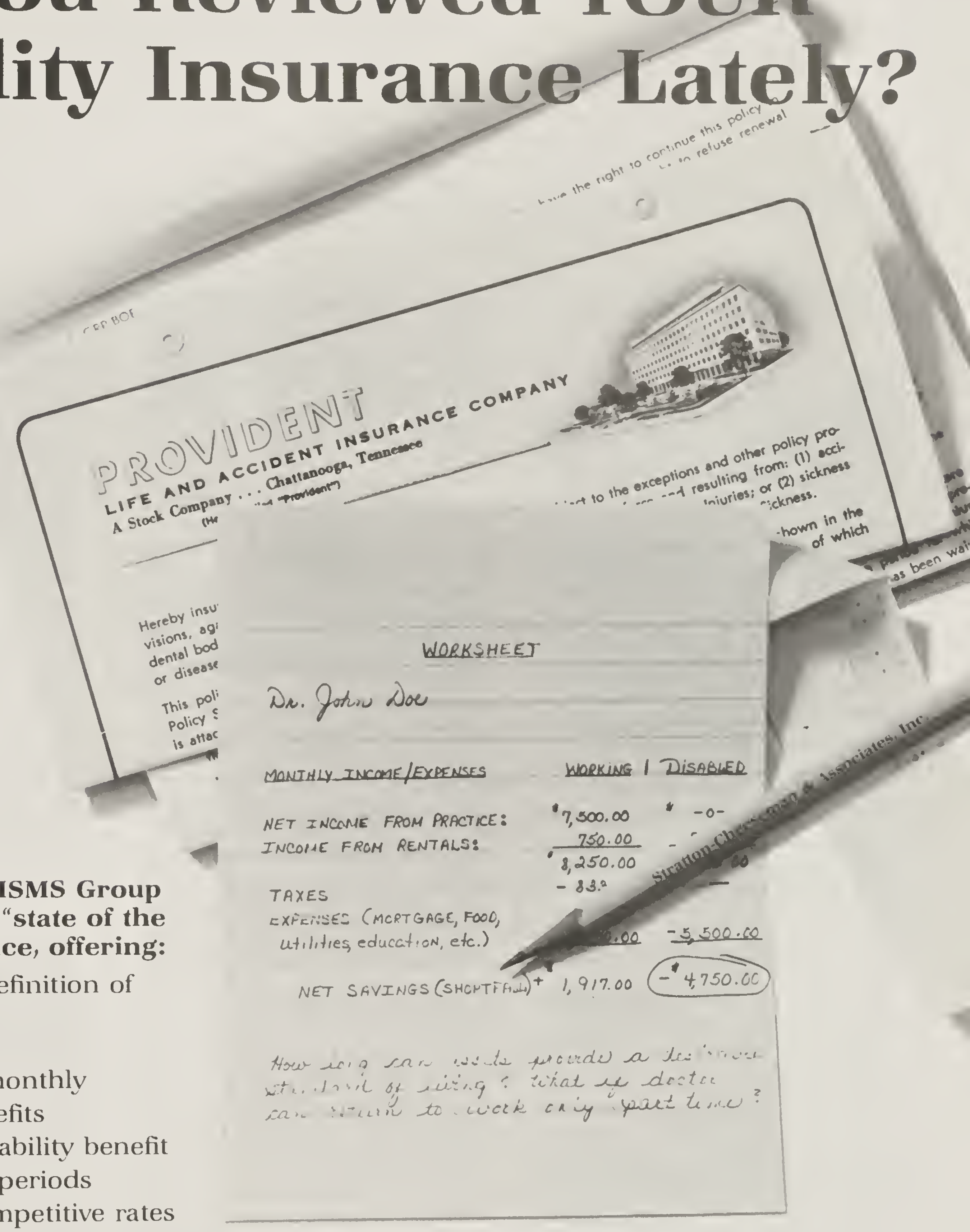

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MEETINGS

MSMS MEETINGS

June

14-19, School Worksite Wellness, MSMS, Michigan Health Council and others, Mackinac Island, contact: Debbie Zannoth, MSMS headquarters (517)337-1351.

17, Effective Writing, a workshop for county medical society editors, executive directors, medical writers and journalism students, Radisson Hotel, Lansing, contact: Judy Marr or Sherry Wellman, MSMS headquarters (517)337-1351.

July

16-19, MSMS Board of Directors Midsummer Meeting, Deer Lake, Boyne Mountain, contact: William Madigan (517)337-1351.

September

23, MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

October

20, County Medical Society Executives Meeting, MSMS headquarters, East Lansing, contact Kevin Kelly, MSMS headquarters (517)337-1351.

21, 1987 Public Affairs Leadership Conference, Clarion Hotel and Conference Center, Lansing, contact: Sherry Wellman, MSMS headquarters (517)337-1351.

November

18, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517)337-1351.

AMA MEETINGS

June

21-25, AMA Annual Meeting of the House of Delegates, Chicago Hilton and Towers Hotel, contact: Bruce Ambrose at MSMS headquarters.

July

8-11, AMA National Conference on the Impaired Health Professional. Impaired Health Professionals: Educating Ourselves . . . Educating Others, Drake Hotel, Chicago, contact: Janice J. Robertson, AMA Department of Substance Abuse, 535 N. Dearborn Street, Chicago, IL 60610 (321)645-5083.

MICHIGAN SPECIALTY SOCIETY MEETINGS

June

12, Greater Detroit Area Health Council, Inc., 1987 Annual Meeting, Hotel St. Regis, Detroit 48226, contact: Symond R.V. Gottlieb, secretary (313)963-4990.

25-28, Michigan Otolaryngological Society, Summer Scientific Meeting, The Homestead, Glenn Arbor, contact: Karen Turner, executive secretary (313)567-1640.

July

10, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313) 243-7144.

10-11, Michigan Society of Thoracic Surgeons Annual Meeting, Grand Traverse Resort Village, Traverse City, contact: Rodman E. Taber, MD, secretary (313)567-1640.

10-12, Michigan Dermatological Society, Grand Traverse Resort Village, Traverse City, contact: Debbie Samalis, executive secretary (313) 554-1891.

August

15-16, Michigan Academy of Family Physicians Congress of Delegates, Grand Traverse Resort Village, Traverse City, contact: Janice Klos, chief executive officer (517) 482-7410.

17-19, Michigan Academy of Family Physicians Annual Meeting, Grand Traverse Resort Village, Traverse City, contact: Janice Klos, chief executive officer (517)482-7410.

18-21, Michigan Health Officers Association, Annual General Membership Meeting, Grand Traverse Resort Village, Traverse City, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

19-20, Michigan Society of Thoracic Surgeons Meeting, Grand Hotel, Mackinac Island, contact: Rodman E. Taber, MD, secretary (313) 567-1640.

22-24, 28th Congress of the Michigan Association of the Professions: The Homecoming, Grand Hotel, Mackinac Island. Registration information will be sent to members during the early summer.

September

4, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313) 243-7144.

October

2, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313) 243-7144.

NATIONAL SPECIALTY SOCIETIES

June

2-5, Society of Nuclear Medicine Annual Meeting, Toronto, contact: Henry L. Ernstthal, Executive Director, 136 Madison Avenue, New York, NY 10016 (212)889-0717.

21-26, College of American Pathologists, American Society of Clinical Pathologists Annual Meeting, Washington, DC, contact: Robert A. Dietrich, MD, 2100 W. Harrison Street, Chicago, IL 60610 (312)738-1336.

July

2-5, American College of Physicians, Topics in Emergency Medicine, Inn on the Park, Toronto, Ontario, Canada, contact: American College of Physicians, 800-523-1546.

15-19, American Academy of Dermatology Summer Session, Anaheim, CA, contact: American Academy of Dermatology, (312)869-3954.

16-18, American College of Obstetricians and Gynecologists, Gynecologic Surgery and Urology, Westin Hotel, Toronto, Ontario, Canada, contact: American College of Obstetricians and Gynecologists (202)638-5577.

22-25, American Academy of Pediatrics, General Pediatrics, Hotel Meridien, Vancouver, Canada, contact: American Academy of Pediatrics, 800-433-9016.

23-25, American College of Obstetricians and Gynecologists, Infertility, Laparoscopy and Hysteroscopy, Huntley Lodge, Big Sky, MT, contact: American College of Obstetricians and Gynecologists, (202)638-5577.

August

3-7, American College of Physicians, 35th Annual Internal Medicine Update and Board Review, University of Southern California School of Medicine, Los Angeles, CA, contact: American College of Physicians 800-523-1546.

6-8, American College of Obstetricians and Gynecologists, Update in Obstetrics, Four Seasons Hotel, Vancouver, BC, Canada, contact: American College of Obstetricians and Gynecologists (202)638-5577.

13-15, American College of Obstetricians and Gynecologists, Advanced Ultrasound, Silverado NAPA, CA, contact: American College of Obstetricians and Gynecologists, (202)638-5577.

14-17, American Academy of Family Physicians Annual Meeting, San Francisco, contact: Robert Graham, MD, 1740 W. 92nd Street, Kansas City, MO 64114.

17-21, American College of Physicians, 7th Annual Hilton Head Conference: Update on Critical Care Medicine, Hyatt on Hilton Head Island, Hilton Head, SC, contact: American College of Physicians, 800-523-1546.

17-18, American Academy of Facial, Plastic and Reconstructive Surgery Annual Meeting, Chicago, contact: Lee VanBremen, PhD, 1101 Vermont Avenue, NW, Suite 404, Washington, DC 20005 (202) 842-4500.

20-24, American Academy of Otolaryngology, Head and Neck Surgery, Chicago, contact: Jerome C. Goldstein, MD, 1101 Vermont Avenue, NW, Suite 303, Washington, DC 20005 (202)289-4607.

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

June

3, Current Topics in Blood Banking: 14th Annual Symposium, Pre-Conference Workshop. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201. **Sponsor:** The University of Michigan Medical School, Department of Pathology. **Contact:** Gayle Fox, Towsley Center for Continuing Medical Education, Box 0201, The University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 4 hours Category I Credit.

4-5, 13th Annual Kalamazoo Symposium for Michigan Neonatologists and Neonatal Fellows. Location: Gilmore Center for Health Education, Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Neonatology Services of the Pediatric Section, Bronson Methodist Hospital and Mead Johnson Laboratories. **Contact:** John V. Hartline, MD, Neonatology Services of the Pediatric Section, Bronson Methodist Hospital, 252 East Lovell, Kalamazoo 49007. **Approved for:** 7.25 hours Category I Credit.

4-5, Current Topics In Blood Banking: 14th Annual Symposium. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor 48109-0201. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Gayle Fox, Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 12 hours Category I Credit.

10-12, Clinical Laboratory Computer Symposium. Location: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201. **Sponsor:** University of Michigan Medical School, Department of Pathology. **Contact:** Betty Phillips, Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 14.6 hours Category I Credit.

11-12, A Healthy Future for Michigan's Mothers and Babies. Location: Clarion Hotel, Lansing. **Sponsor:** Michigan Healthy Mothers/Healthy Babies Coalition, and Detroit Wayne County Infant Health Promotion Coalition, the Greater Detroit Area Health Council, Inc., March of Dimes, Michigan Department of Public Health, Michigan Public Health Association, and New Detroit, Inc.. **Contact:** Terry Wright (313)876-4667 or Pamela Walsh (313)963-4990. **Approved for:** 10.5 hours Category I Credit.

12-14, Urology Outing. Location: Grand Traverse Resort, Traverse City. **Sponsor:** Wayne State University School of Medicine, Division of CME. **Contact:** Gail Bank, PhD, Director, Continuing Medical Education, Wayne State University School of Medicine, 4201 St. Antoine, 4-H, Detroit 48201 (313) 577-1180. **Approved for:** 12 hours Category I Credit.

21-26, Twenty Third Annual Northern Michigan Summer Conference: An Update on Common Clinical Concerns. Location: Hilton Shanty Creek, Bellaire **Sponsor:** University of Michigan Medical School, Office of Continuing Medical Education. **Contact:** Betty Phillips, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 20.5 hours ACCME Category I Credit and 19.0 hours American Academy of Family Physicians Credit.

25-28, Infectious Diseases. Location: Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** Michigan State University College of Osteopathic Medicine Alumni Association. **Contact:** Sandy Kilborn, Director of Continuing Medical Education, Michigan State University, College of Osteopathic Medicine, A306 East Fee Hall, East Lansing 48824-1316 (517)353-9714. **Approved for:** 10 hours OAO Category I Credit.

July

5-8, Internal Medicine Update. Location: Grand Hotel, Mackinac Island. **Sponsor:** The University of Michigan Medical School, Department of Internal Medicine, Ann Arbor. **Contact:** Gayle Fox, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 11.25 hours Category I Credit.

17-18, Practical Approach to the Diagnosis and Management of Cardiopulmonary Diseases. Location: Grand Traverse Resort Village, Traverse City. **Sponsor:** Michigan State University College of Osteopathic Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 E. Fee Hall, East Lansing, MI 48824-1316. **Approved for:** 10 hours Category I Credit.

30-31, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Traverse City. **Sponsor:** Munson Medical Center. Traverse City. **Contact:** Elaine Gaines, medical education secretary, Munson Medical Center, 1105 Sixth Street, Traverse City 49684-2386, (616) 922-9546. **Approved for:** 9 hours Category I Credit.

31-8/2, Tutorial on Level II Myofascial Release Technique. Location: The Homestead Resort, Glen Arbor. **Sponsor:** Michigan State University College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 East Fee Hall, East Lansing, MI 48824-1316. **Approved for:** 24 hours Category I Credit.

August

8-9, Diabetes Program. Location: Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** University of Michigan Medical School. **Contact:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 10 hours Category I Credit.

9-14, Symposium on Breast Disease: Diagnostic Imaging and Current Management. Location: Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** University of Michigan Medical School, Department of Radiology and Office of Continuing Medical Education. **Contact:** Gayle Fox, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 20.3 hours Category I Credit.

14-17, Infectious Diseases. Location: Grand Hotel, Mackinac Island. Sponsor: University of Michigan Medical School. Contact: Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Box 0201, Ann Arbor 48109-0201 (313)763-1400. Approved for: 10 hours Category I Credit.

31-9/3, Advanced Cardiac Life Support Provider Course. (August 31 and September 2 Recertification Course—8 Category I Credits—4 for BCLS and 4 for ACLS). Location: Borgess Medical Center, Kalamazoo. Sponsor: Southwestern Michigan Area Health Center, Staff and Patient Education Department. Contact: Claire A. Zieman, Staff and Patient Education, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-8320. Approved for: 25 Category I Credits (4 for BCLS and 21 for ACLS).

September

10-12, Advanced Cardiac Life Support (Provider & Recertification) Course. Location: Gilmore Center of Health Education Bronson Methodist Hospital, Kalamazoo. Sponsor: Bronson Life Support Services and Southwestern Michigan Area Health Education Center. Contact: Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. Approved for: Category I Credit: 20 credits for ACLS and 4 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

10-12, Head and Neck Oncology Research. Location: Towsley Center for Continuing Medical Education, The Universtiy of Michigan Medical School, Ann Arbor 48109-0201. Sponsor: University of Michigan Medical School. Contact: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. Approved for: 24 hours Category I Credit.

12-16, Tutorial On Level I Muscle Energy Technique. Location: Kellogg Center for Continuing Education, Michigan State University, East Lansing 48824. Sponsor: Michigan State University College of Osteopathic Medicine. Contact: Sandy Kilborn, Director of Continuing Medical Education, Michigan State University, College of Osteopathic Medicine, A306 East Fee Hall, East Lansing 48824-1316 (517)353-9714. Approved for: 40 hours of Category I Credit.

16, Current Issues in Chemical Dependency. Location: Saint John Hospital, 22101 Moross Road, Detroit. Sponsor: The Continuing Medical Education Committee of Saint John Hospital. Contact: Mary Ann Richards, Program Coordinator, Continuing Medical Education, Saint John Hospital, Detroit 48236 (313) 343-4000. Approved for: 7 hours Category I Credit.

18-20, Tutorial on Level I Myofascial Release Technique. Location: Kellogg Center for Continuing Education, Michigan State University, East Lansing. Sponsor: Michigan State University College of Osteopathic Medicine and College of Human Medicine. Contact: Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 East Fee Hall, East Lansing 48824-1316 (517)353-9714. Approved for: 24 hours Category I Credit.

19, Emergency Medicine Oral Boards Preparation Workshop. Location: St. Mary's Hospital, Saginaw. Sponsor: St. Mary's Hospital and Michigan State University College of Osteopathic Medicine. Contact: Michigan ACEP, 1305 Abbott Road, Suite 104, East Lansing 48823. Approved for: 5 hours Category I Credit.

24-26, The Grand Rapids 18th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. Sponsor: Michigan State University College of Human Medicine, The International Federation of Societies for Surgery of the Hand, The Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. Contact: Alfred B. Swanson, MD, Blodgett Professional Building, 1900 Wealthy, S.E., Suite 290, Grand Rapids 49506 (616) 774-0440. Approved for: 18 hours Category I Credit.

26-30, Tutorial on Level II Manual Medicine Techniques (Above Diaphragm). Location: Kellogg Center for Continuing Education, Michigan State University, East Lansing. Sponsor: Michigan State University College of Osteopathic Medicine and College of Human Medicine. Contact: Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 E. Fee Hall, East Lansing 48824-1316 (517)353-9714. Approved for: 40 hours Category I Credit.

October

30-11/3, Tutorial on Level II Craniosacral Techniques. Location: Kellogg Center for Continuing Education, Michigan State University, East Lansing. Sponsor: Michigan State University College of Osteopathic Medicine and College of Human Medicine. Contact: Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 E. Fee Hall, East Lansing 48824-1316 (517)353-9714. Approved for: 40 hours Category I Credit.

21, Thyroid Update. Location: Saint John Hospital, 22101 Moross Road, Detroit. Sponsor: The Continuing Medical Education Committee of Saint John Hospital. Contact: Mary Ann Richards, Program Coordinator, Continuing Medical Education, Saint John Hospital, 22101 Moross Road, Detroit 28236 (313) 343-4000. Approved for: 7 hours Category I Credit.

November

5-7, Advanced Cardiac Life Support (Provider & Recertification) Course. Location: Gilmore Center of Health Education Bronson Methodist Hospital, Kalamazoo. Sponsor: Bronson Life Support Services and Southwestern Michigan Area Health Education Center. Contact: Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. Approved for: Category I Credit: 20 credits for ACLS and 6 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

10-12, 1987 MSMS Annual Scientific Meeting. Location: Hyatt Regency Dearborn. Sponsor: MSMS and cooperating specialty societies, sections, medical school departments and hospitals. Contact: Sherry L. Fent, Chief, Physician Education, MSMS, P.O. Box 950, East Lansing, 48826-0950 (517)337-1351. Approved for: a maximum of 18 Category I Credit hours for the three day conference.

20-22, Tutorial on Manual Medicine Techniques Applied to the Extremities. Sponsor: Michigan State University College of Osteopathic Medicine and College of Human Medicine. Contact: Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 E. Fee Hall, East Lansing 48824-1316 (517)353-9714. Approved for: 24 hours Category I Credit.

CLASSIFIED

The rate for each classified advertisement in *Michigan Medicine* is 40¢ per word, with a minimum charge of $20.00. Copy for classified advertisements should be received not later than the first of the month preceding the month of publication.

POSITIONS OPEN

GULF COAST BEAUTIFUL MOBILE BAY AREA-substantial guaranteed income with time to enjoy sunbelt lifestyle. BE/BC—family physicians, IM, or EM to join medical group with multiple urgent care/family practice clinics. Contact: Ms. Vogel, 1168 S. Beltline Highway, Mobile, Alabama 36609 (205)343-5263.

NEED A GENERAL SURGEON OR COLON-RECTAL SURGEON for suburb of Detroit. $75,000 to $85,000 as annual salary first year according to qualification. Opportunity for gradual partnership after the first year. Please send CV to A.T., PO Box 5131, West Bloomfield 48033.

PHYSICIAN WANTED INTERNAL MEDICINE: Two openings for full time Board Qualified and Board Eligible Internal Medicine physicians for multi-specialty clinic with privileges at large suburban Detroit hospital. Salary commensurate with training and experience. Send resume to Box 103, Michigan Medicine, PO Box 950, East Lansing 48826-0950.

GENERAL PRACTICE Need for additional physician in growing community located in southern Michigan. Established office space, coverage and referring specialists available. Local hospital affiliated with 625 bed medical center. Good family environment with excellent recreation in multilake area. Guarantee plus productivity and benefits provided. Please respond to Box 104, Michigan Medicine, PO Box 950, East Lansing 48826-0950.

RADIATION ONCOLOGY Partnership option. Central Wisconsin on lake. Supported by two hospitals with 250K drawing area. Outdoor amenities: hunting/fishing/water sports. Compensation package: 6 figure guarantee plus percentage and full benefits. Board Certified with 2 years experience a plus. Contact Bob, Tyler and Company, 9040 Roswell Road, Atlanta, GA 30338. Collect (404) 641-6411.

INTERNIST WITH AN INTEREST IN GASTROENTEROLOGY needed to join a Cardiologist/Internist in a rural Louisiana town from July, 1987. Attractive first year salary, benefits, and early partnership. If interested, send CV to: Manzoor H. Qazi, MD, 1101A Port Arthur Terrace, Leesville, LA 71446.

ORTHOPEDIC SURGEON An excellent opportunity for an orthopedic surgeon to join a single specialty four man group that is expanding. Prefer hand or spine fellowship training but will consider general orthopedist. Clinic located within new 300 bed hospital complex. Community offers educational and recreational opportunities. Guaranteed salary and excellent fringe benefits. Send curriculum vitae and letter of inquiry to: Clinic Coordinator, Bone & Joint Clinic, SC, 425 Pine Ridge Blvd., Suite 300, Wausau, WI 54401 (715)842-3202.

OPHTHALMOLOGY SOUTHEASTERN WISCONSIN Large multi-specialty clinic located near Milwaukee is seeking a second BE/BC ophthalmologist. Non-surgical orientation preferred. Excellent salary and fringe benefits. Interested parties please send inquiries and CV to: Joe Scholl, Manager, Physician Recruitment, PO Box 427, Menomonee Falls, WI 53051.

FAMILY PRACTICE PHYSICIAN BE/BC WANTED Senior member of well managed two physician family practice corporation retiring August 1. Well established practice in south suburban Dayton, Ohio. Better-than-competitive salary, benefits, and profit sharing. Partnership opportunity. Ten physicians co-op for night/weekend call. Satellite hospital 1.5 and teaching parent hospital 7 miles from office. Full specialty back-up. No obstetrics. On site laboratory and x-ray. Outstanding cultural, educational, and recreational opportunities including those in nearby Cincinnati with major league sports. Contact Verne H. Dodson, MD, 1012 East Central Avenue, Miamisburg, Ohio 45342. Phone (513)866-1012.

CHILD/ADOLESCENT PSYCHIATRIST Board eligible, preferred certified, to work closely with a multidisciplinary team in an accredited 40 bed child and adolescent psychiatric hospital, an agency of the Michigan Department of Mental Health. We are located in beautiful Traverse City, Michigan. A water and winter wonderland. Traverse City is the cultural and medical center for Northern Michigan. Skiing, fishing, hunting and sailing is at your doorstep. We have an excellent school system and a pollution free, low crime environment. Salary depending upon qualifications to $86,000 with remarkable fringe benefits. Send curriculum vitae and three letters of reference to Arnell Engstrom Children's Center, Box C, Traverse City 49684, or call Robert E. Davidson, MD or Paul Surratt, PhD, at (616)922-5400. An equal employment opportunity employer.

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ANESTHESIOLOGIST WANTED to join Central Wisconsin Anesthesiology, S.C. which consists of four established, hospital based anesthesiologists. All specialties are served including open heart, neuro, obstetrics and gynecology. If interested, phone (715) 845-5505 or write to: Central Wisconsin Anesthesiology, SC, 425 Pine Ridge Blvd., Suite 207, Wausau, WI 54401.

EMERGENCY PHYSICIANS NEEDED Chicago, Illinois. Full or part time. Prefer Board Certified or Eligible in Emergency Medicine, or at least three years full time experience. New contractual situation with new group will offer outstanding growth possibilities and excellent compensation. Take advantage of this exciting opportunity to work and live in dynamic Chicago. Send resume as soon as possible to: MEDICAL DIRECTOR, 666 North Lake Shore Drive, Lake Residence, Suite 1506, Chicago, Illinois 60611, or call (312)944-6969. Please don't delay in responding to this wonderful opportunity as there are only four positions available.

GENERAL SURGEON/COLO-RECTAL MD or DO for busy, out-patient proctology/general surgery practice. Excellent opportunity for future independence and freedom. Franchise concept. Must explore. Send resume to: Hemorrhoid Clinics of America, 22000 Greenfield Road, Oak Park 48237, or call (313)967-4140.

EMERGENCY ROOM PHYSICIANS—full or part time positions. Rural Southwest Michigan. Competitive reimbursement; ACLS required; ATLS preferred. Nice rural community. Please send CV to President, SMES, 4341 S. Westnedge, Suite 1112, Kalamazoo 49008.

FAMILY PRACTITIONER AND INTERNAL MEDICINE SPECIALISTS to join seven doctor Family Practice Clinic in Cloquet, Minnesota, a community of 12,000 (30,000 service area) located 20 minutes from Duluth-Superior. Clinic facility is located one block from modern, well equipped 77 bed hospital. Cloquet enjoys a stable economy (forest products). Additionally, our community is noted for its excellent school system. First year salary guarantee, paid malpractice, health and disability insurance, vacation and study time. Contact John Turonie, Administrator, Raiter Clinic, Ltd., 417 Skyline Blvd., Cloquet, MN 55720. Telephone (218) 879-1271.

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50% OFF PREVIOUSLY OWNED MEDICAL, laboratory, x-ray, ultrasound equipment. We buy, sell, broker, repair. Appraisals by certified surgical consultant. MEDICAL EQUIPMENT RESALE & REPAIR, INC., 24026 Haggerty Road, Farmington Hills 48018 (313)477-6880.

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SOLO GYNECOLOGY PRACTICE FOR SALE. This solo gynecology practice has done no obstetrics for ten years. In the past six years (1981 through 1986) actual business was 2.72 million dollars and actual money collected was 2.49 million dollars. Mid Michigan community with excellent hospital (one), schools, parks, churches, colleges and golf courses. Ann Arbor and East Lansing are nearby. An experienced and superbly qualified team (certified registered nurse practitioner, registered nurse, master word processor and a receptionist) is willing to stay on. Owner will transmit clinical skills and introduce buyer to patients. Please reply to Box 101, Michigan Medicine, PO Box 950, East Lansing 49926-0950.

SURGICAL PRACTICES AVAILABLE FOR SALE in Pontiac and St. Clair Shores. Call Commonwealth Health Care Group, Inc. (313)548-9900.

O.P.C. PROVIDER NUMBER AVAILABLE for sale in Southfield, Commonwealth Health Care Group, Inc. (313)548-9900.

UROLOGY PRACTICE FOR SALE in Western Michigan, Grossing $300,000 plus. Call or write: Melvin Turbow, Michigan Practice Brokerage Corporation, (313) 353-6310, or Michigan Practice Brokerage Corporation, 20300 Civic Center Drive, Suite 230, Southfield 48076-4105.

OAK PARK PRACTICE FOR SALE Excellent starter or merge opportunity. Doctor leaving Michigan. Established general practice— Great location—busy intersection—pleasant surroundings—Well equipped—3 exam rooms, lab, and x-ray room. Good patient load. Excellent parking conditions—Call Professional Practice Sales, Inc., Herbert Silverman, Associate Broker, (313)569-7336, 27208 Southfield Road, Lathrup Village 48076.

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UTICA-AUBURN-ROCHESTER-TROY General Practice for sale. Prime location near busy intersection. Equipment in excellent condition, including automatic processor, x-ray, lab, Ekg, nuclear, etc. Troy Beaumont Hospital nearby. Grossing $311,000. Only $30,000 down will move you in. Call Professional Practice Sales, Inc., Herbert Silverman, Associate Broker, (313)569-7336, 27208 Southfield Road, Lathrup Village 48076.

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Where do we stand now?

By Carl A. Gagliardi, MD

Carl A. Gagliardi, MD, Dearborn pediatrician, assumed the office of MSMS president Saturday, April 25 at the MSMS House of Delegates meeting at the Amway Grand Plaza Hotel, Grand Rapids.

On April 25, 1987, I began what I expect to be one of the most exciting years of my life. It is truly a great honor to have been elected president of this Michigan State Medical Society, and I intend to do my very best to fulfill my duties and carry out the responsibilities of this office.

I have frequently been asked the question, "After the busy year you spent as chairman of the Board of Directors of MSMS in 1985-86, what do you expect to do as president to top that year?"

Then, as now, the malpractice problem was uppermost in all physicians' minds and consumed a tremendous amount of my time. Lou Zako, MD, as chairman of the Task Force on Professional Liability, and I, as chairman of the Board, worked untoward hours formulating and then fine-tuning our goals. The MSMS staff and our legal counsel, Richard Weber, assisted immeasurably by monitoring our activities and offering superb advice.

The physicians of Michigan, thousands of them, became more politically active than ever before. They communicated with their patients and the public at large, and the dilemma of the malpractice problem became better understood.

Doctor Gagliardi

In addition to our legislative efforts, we spent many hours in negotiations with the trial lawyers, the medical liability insurance carriers and the Michigan Hospital Association, all under the able direction of Professor Robben Fleming, Governor Blanchard's personal factfinder. We came very close to developing the most innovative patient compensation fund proposed anywhere in the United States. Under that proposal there would have been an absolute cap on physicians' and hospitals' total liability. Unfortunately, the opportunity was lost because one of the parties to the negotiations (not the physicians) was unwilling to accept the plan and because valuable time was lost in getting the proposals to the legislators.

So where do we stand now? Was 1985-86 a good or bad time for liability reform? These questions are difficult to answer accurately, but the truth probably lies somewhere in the middle. We did succeed in getting some reform measures through the legislature, but not nearly enough. The system is still broken and needs to be fixed.

Friendships were made in the process even though we did not always agree with each other. I like to think that Governor Blanchard, House Speaker Gary Owen, Senate Majority Leader John Engler and many other senators and representatives, too numerous to name specifically, became interested in our plight and will continue to keep the dialogue open and strive for a just solution.

The outlook

Now back to the original question I set out to answer. Will 1987 top 1985-86? I am unable to answer that now, but I do promise to devote all of my time and energy to the liability problem that confronts us all.

We in the medical profession need to work together and speak with a single voice. I told you last year when I was selected to be president-elect, that we would win this battle if we remain unified, and I still hold to that point of view. Victory will not come easily, or quickly, but we must win because we are right. Our children, our grandchildren and all residents of this great state deserve to have the best medical care that is available in the world. We must not allow the profession of medicine to be destroyed. ☐

MICHIGAN MEDICINE

JUNE 1987 AWARD-WINNING JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY VOL. 86, NO. 6

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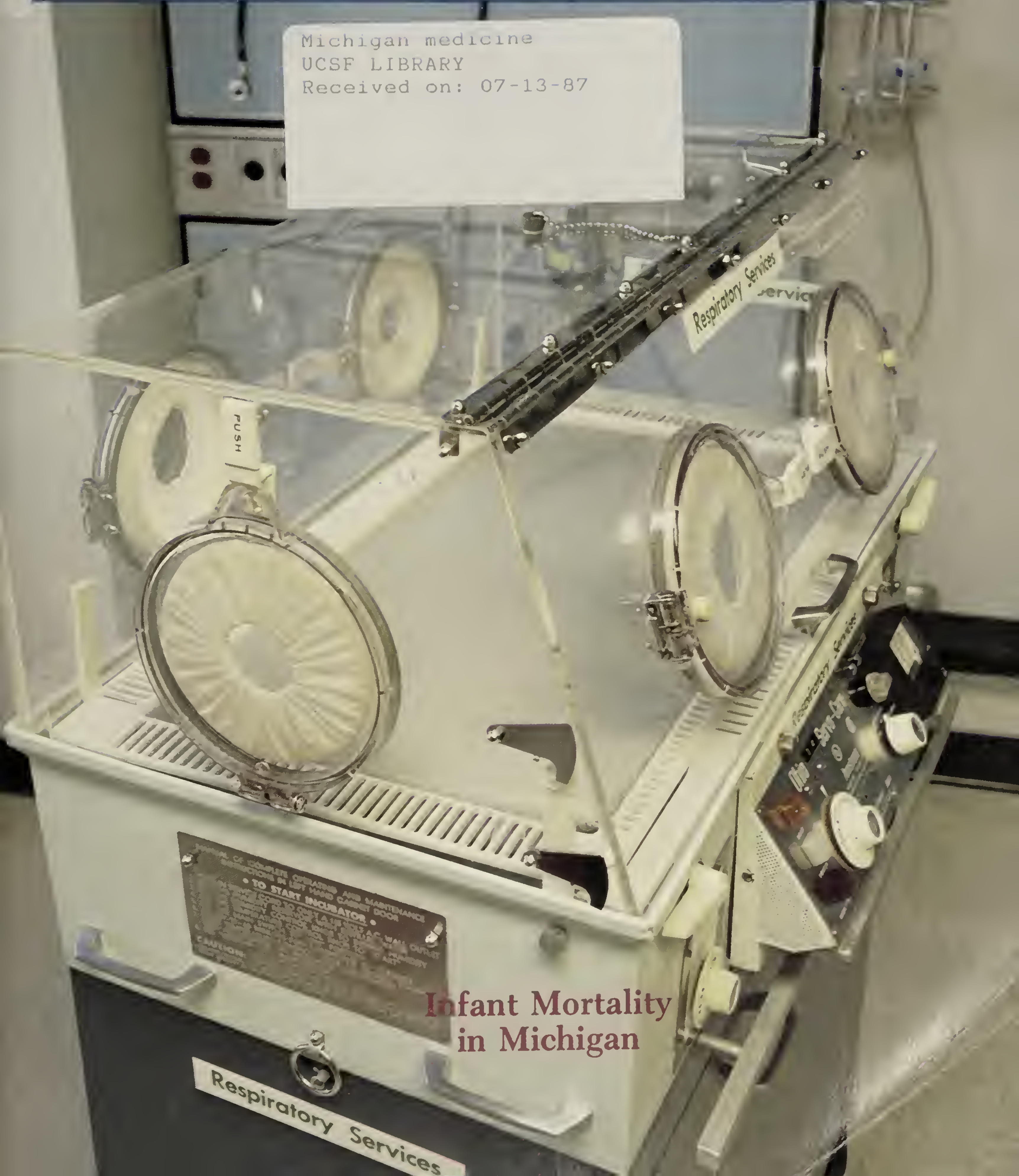
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Infant Mortality in Michigan

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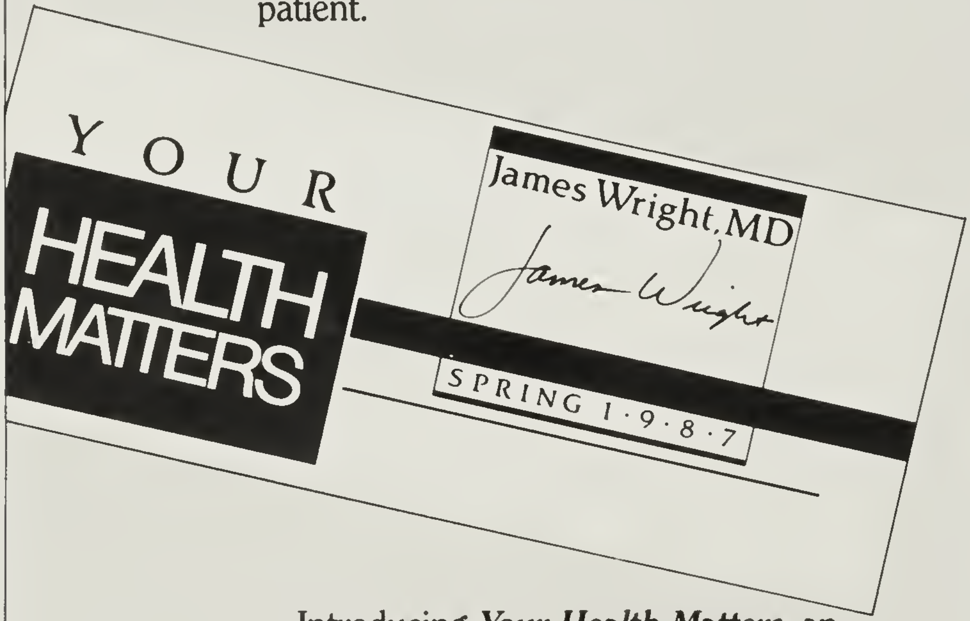

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MICHIGAN MEDICINE

JUNE 1987 VOL. 86 NO. 6

Special Report

Infant mortality in Michigan — Only nine states and the District of Columbia have higher infant mortality rates than does Michigan. In 1985, Michigan's overall infant mortality rate was 11.4 per 1,000 live births. Within the state there was a striking gap between the infant mortality rate for blacks (22.5 per 1,000 live births) and for whites (9.5 per 1,000 live births). An 86-member task force studied the spectrum of problems involved and recently issued its recommendations. Our report features an introduction by task force chairman Charles F. Whitten, MD; a summary of the group's findings; comparative statistics; observations by task force member Robert P. Lorenz, MD, and a progess report on brain damage in newborns. 364

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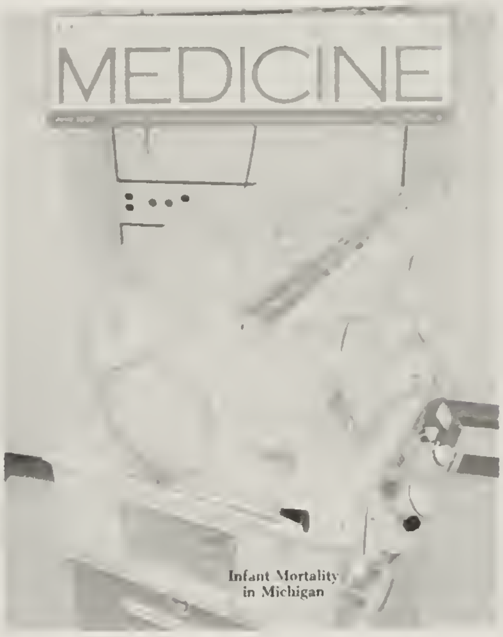

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In next month's issue of *Michigan Medicine*: MSMS launches a public and professional relations campaign.

Cover photo by Kim Kauffman.

Senator John Schwarz, MD inspires action

By Fred W. Bryant, MD

Doctor Bryant

The MDPAC luncheon is sandwiched in the middle of the full menu of activities at the MSMS House of Delegates. National dignitaries (such as John Coury, MD, AMA president and Bill Hotchkiss, MD, AMA president-elect), local notables (outgoing and incoming MSMS Presidents Thomas Berglund, MD, and Carl Gagliardi, MD), assorted leaders, and those physicians politically active have an opportunity to convene, chat between bites, and to listen. The format of the affair includes a couple of keynote speakers, generally one each from the Michigan House and Senate.

This year's Senate speaker was Sen. John Schwarz, MD.

Unique in that he is the only physician in the state legislature, Senator Schwarz (R-Battle Creek) won his seat in a close election last November. Six months into his freshman year, Doctor Schwarz already occupies important positions on several Senate committees. He is chairman of the Committee on Education and Mental Health, serves as vice-chairman of the Committee on Commerce and Technology and sits on the Senate Committee on Health Policy.

Doctor Schwarz observes that physicians, by virtue of their extensive education, decision-making responsibilities and frequent communication with people, unwittingly train themselves for public office. Pointing out that doctors in our country participate in government far less than in other nations, he urges us to at some stage of our lives be active in government.

He suggests serving on a planning commission, PTA or city council. He declares that physi-

Continued on facing page

Doctor Bryant, Royal Oak ophthalmologist, is MSMS president-elect.

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Transplant projects

The MSMS Board of Directors recently presented a check to the MSMS Auxiliary Committee for Health Projects toward its work with organ procurement agencies during Organ Donation Awareness Week. The following letter was recently received by Robert E. Paxton, MD, chairman, MSMS Board of Directors:

Thank you and the MSMS Board of Directors for your check in the amount of $1,100.00. This contribution enabled the Organ Donor Coalition to purchase four additional billboards, for a total of twelve, to be placed in metro Detroit, Flint, and Grand Rapids locations during the month of April.

The organ donor organizations are appreciative of your support in this, their most recent endeavor.

Betty Drew, past president
MSMS/Auxiliary

Clinical alert: intraocular lenses

The American Academy of Ophthalmology issues this statement: "Clinical Alert 3/1—Complications of closed loop flexible and semi-flexible anterior chamber intraocular lenses."

Recent evidence suggests that closed loop flexible and semi-flexible anterior chamber lenses are associated with a disproportionately high incidence of serious vision-threatening complications. One of these lenses, the Azar 91Z (IOLab) lens has already been voluntarily removed from the market by the manufacturer. Other varieties, however, particularly Lieske (Surgidev Corp), Stableflex (Optical Radiation), and other Lieske-type IOLs have been reported to pose similar risks.

While most patients do well with these lenses, some patients who have received these lenses may present to ophthalmologists with vision problems. In addition, continued use of these lenses may pose a greater-than-average risk for severe complications in patients undergoing cataract surgery.

Because of these problems, FDA Ophthalmic Devices Panel has recommended to the Commissioner of the Food and Drug Administration that implantation of the Leiske, Stableflex and other 91Z-type lenses be done only as part of a core investigation and should no longer be available for adjunct safety studies.

The FDA, for its surveillance of investigational intraocular lenses, has to rely on ophthalmologists to report adverse reactions to the manufacturers, who in turn are required to notify the FDA. Compliance with this process by explanting surgeons has so far been disappointingly low.

The Academy strongly recommends to its members that they inform the manufacturer whenever an intraocular lens is explanted. The following minimal information should be sent:

1) Patient's name;
2) patient's social security number;
3) name of implant surgeon, if known;
4) which eye;
5) date of implant; and
6) best possible description of implant type.

If the manufacturer is unkown, please send this information to: US Food and Drug Administration (HFZ/460), IOL Branch, 8757 Georgia Avenue, Silver Spring, MD 20910; 1-800-638-6725.

Board of Directors, American
Academy of Ophthalmology
San Francisco

SCHWARZ/Continued

cians in general are admirably suited for civic duty.

There is no paradox in the case of Senator/Doctor Schwarz. An elegant orator but not extravagant of speech, he is purposeful, direct, expressive and persuasive—a paragon doctor in government: capable, aware, effective.

We note with satisfaction the induction of John Schwarz into the Senate and the early distinction which has come to him. The legislature is richer for his talents and the people of Michigan stand to benefit from the efforts of this physician in public service.

The future is bright. All those in favor of Senator John J. H. Schwarz, MD, please signify by saying "Aye"! ☐

Task force identifies problems, recommends solutions

By Charles F. Whitten, MD

Like other states with large urban centers and their attendant problems of poverty, Michigan has an unacceptably high infant mortality rate.

Gloria Smith, PhD, director of the Michigan Department of Public Health, in July of 1985 convened a Task Force on Infant Mortality to develop recommendations to deal with the tragedy of infant mortality in our state.

Monumental task

As we approached our first meeting, we recognized that the task before us was monumental. The problems of infant mortality are not solely the problems of the traditional public health system. Rather, they encompass the wide spectrum of virtually all human service programs. Furthermore, there is a correlation between poverty and high rates of infant mortality that has been well documented at both the state and national levels. Therefore the task force was challenged to find ways to ameliorate the effects of poverty, a factor it could not eradicate or reduce.

The membership of the Task Force reflected the need for the broadest possible approach to the problem. Among its 86 members were experts in social service programs, community organizing, and broad human service programs.

The Task Force was divided into six working groups and charged with developing a series of recommendations for addressing specific aspects of the overall infant mortality problem.

There was a host of good ideas developed by the working groups which could make a real contribution to reducing Michigan's overall rate. However, the task force recognized that just presenting a service of "good ideas" was not enough. Like state governments all across the country, Michigan is faced with an ever-rising number of needs and a static ability to meet those needs. The very real constraints of limited resources had to be factored into the recommendations of the task force if the group's work was to be considered seriously and carefully by decision-makers in state government.

A primary focus was on those recommendations which could reduce the black infant mortality rate in the state (because it was in that area that the greatest impact could be most easily achieved); and which could result in greatest possible immediate pay-off in terms of dollars expended versus women reached.

Five-year plan

Further deliberation and analysis led to the development of a five-year plan for systematically attacking the state's infant mortality problem.

The fundamental concepts embodied in the plan are contained in its three service objectives:

1) To increase the number of women whose health is monitored early and continuously during pregnancy and who receive the medical and ancillary services necessary to maximize their potential for delivering healthy full term infants.

2) To decrease the number of unintended pregnancies, encourage appropriate spacing between pregnancies, and encourage healthy lifestyles in preparation for pregnancy.

3) To increase the number of high-risk newborns who receive adequate comprehensive neonatal and postnatal care.

The task force's report has unique characteristics that distinguish it from traditional task force and advisory committee reports. Rather than just a litany of innovative recommendations, it provides a goal to be achieved; a detailed five year plan; a set of objectives; a listing of the activities that must be undertaken to achieve the objectives; a rationale for each of the proposed activities, and finally, the expectations for the reduction in infant mortality *if* the plan is adequately funded and fully implemented.

I am proud of the outcome of the Task Force on Infant Mortality. The five-year plan we have developed will, if implemented, have a significant effect in reducing Michigan's infant mortality rate and in closing the gap between the black and white rates in our country. ☐

Doctor Whitten is chairman of the Michigan Task Force on Infant Mortality.

Five year plan targets infant mortality in Michigan

The following article is an executive summary of the Task Force on Infant Mortality's report to Gloria Smith, PhD, state health director.

Only nine states and the District of Columbia had higher infant mortality rates than Michigan in 1984, the most recent year for which comparative data are available. Michigan's overall infant mortality rate for 1985 was 11.4 per 1,000 live births, and within the state there was a striking gap between the infant mortality rate for blacks (22.5 per 1,000 live births) and for whites (9.5 per 1,000 live births). In response to this grim situation, the Michigan Department of Public Health (MDPH) convened a task force on infant mortality in July, 1986 to analyze the problem and formulate public policy recommendations to alleviate it. Composed of experts from various arenas, the task force was divided into six working groups, each addressing a specific dimension of the infant mortality issue: planning for pregnancy; access to health care for mothers and infants; the content of prenatal care; postneonatal care; special problems of minority populations; and collecting and analyzing data to assess the problem and evaluate the effectiveness of public health responses.

Much of the present infant mortality problem has its roots in poverty of which minorities bear a disproportionate share of the burden . . .

In Michigan, the rate of infant mortality—that is, deaths during the first year of life—has decreased dramatically since the turn of the century when more than 150 of every 1,000 children born died in their first year. Better living conditions, the control of infectious diseases, and other public health initiatives have been responsible for much of this improvement. Technical advances in care for newborns contributed a great deal to lowering the infant mortality rate in the 1960s and the 1970s. Nevertheless, the overall rate is still too high, and the gap between the rates for the state's black and white populations is clearly unacceptable.

Much of the present infant mortality problem has its roots in poverty—of which minorities bear a disproportionate share of the burden—and the deprivation of medical services and adequate nutrition that poverty brings. Human service programs cannot address the causes of poverty, but they can help reduce the effects of poverty on the health of mothers and infants. Adequate prenatal medical care and nutrition and family planning services, which aid in the proper spacing of pregnancies, can help reduce the number of babies born with low birthweight (5 pounds, 8 ounces or under), one of the major factors associated with infant mortality. Reducing the number of low birthweight babies is enormously cost effective; the costs of the intensive medical care needed by infants born too small or too soon greatly exceed the costs of providing preventive services. Adequate medical services for newborns, nutrition assistance for mothers and infants, and child care training for new parents can also help increase the number of infants who survive the crucial first year of life. Such comprehensive prenatal and postnatal measures also improve infant health in general, helping babies grow into adults more likely to be self-sufficient and productive.

The US Surgeon General has proposed that the nation lower its overall infant mortality rate to 9 per 1,000 live births by 1990, with no subgroup's rate exceeding 12 per 1,000. The force proposes that *Michigan initiate programs that can achieve substantive reduction in infant mortality and continue them at least until the state's infant mortality rates for all groups are below the national average or reach the surgeon gen-*

Continued on next page

PLAN/Continued

eral's goal. To accomplish this, the task force formulated a comprehensive five year plan designed to achieve significant results in the short term by focusing on the populations at highest risk of infant mortality. This means concentrating efforts on the 13 Michigan counties in which nearly all black infant deaths, and a majority of white deaths, occur: Berrien, Calhoun, Genessee, Ingham, Jackson, Kalamazoo, Kent, Macomb, Muskegon, Oakland, Saginaw, Washtenaw and Wayne. The plan has four objectives:

1. Increase the number of women whose health is monitored early and continuously during pregnancy and who receive the medical and ancillary services necessary to maximize their potential for delivering healthy full-term infants.
2. Decrease the number of unintended pregnancies, encourage appropriate spacing between pregnancies, and encourage healthy lifestyles in preparation for pregnancy.
3. Increase the number of high-risk newborns who receive adequate, comprehensive neonatal and postneonatal care.
4. Improve the state's capacity to gather, monitor, analyze, disseminate and use data on (a) infant mortality and morbidity (poor health) and (b) the effects of public health interventions.

The task force recommends specific measures for meeting each objective in the five-year plan. Objective one—improving the prenatal care system— will be met by:

- increasing the number of supervised teams of paraprofessionals bringing women into the prenatal care system and assisting them in making effective use of it;
- providing comprehensive prenatal care, including individual case management where necessary, to women at risk or at high risk of bearing unhealthy infants;
- expanding and improving public information efforts to motivate women to seek and use prenatal care and recognizing the need for special efforts to reach specific cultural groups;
- providing more transportation, baby-sitting, advocacy, and other services to low-income women to help them obtain prenatal care services;
- giving health care providers reimbursement incentives to serve low income families through the Medicaid and Prenatal/Postpartum Care (PPC) programs; and
- providing state funds to the federally and locally funded Supplemental Food Program for Women, Infants, and Children (WIC) and instituting competitive bidding for suppliers of infant formula to the WIC program.

Objective two—improving family planning—will be met by increasing funding for family planning services for both men and women. In addition to medical services, this will include education and information as well as treatment and referral for social problems. Only slightly more than half of those now needing family planning services receive them, even though such services have been shown to reduce unintended pregnancies substantially. The MDPH will also explore ways to reach teenagers at high risk of unplanned pregnancies with these services.

Objective three—improving the quality of neonatal and postneonatal care— will be met by programs to provide comprehensive neonatal and postneonatal care to all infants at high risk of death. This will include psychosocial and nutrition services as well as medical and nursing services. Programs to improve prenatal care, of course, also improve the chances of neonatal and postneonatal survival, but special efforts are needed as well.

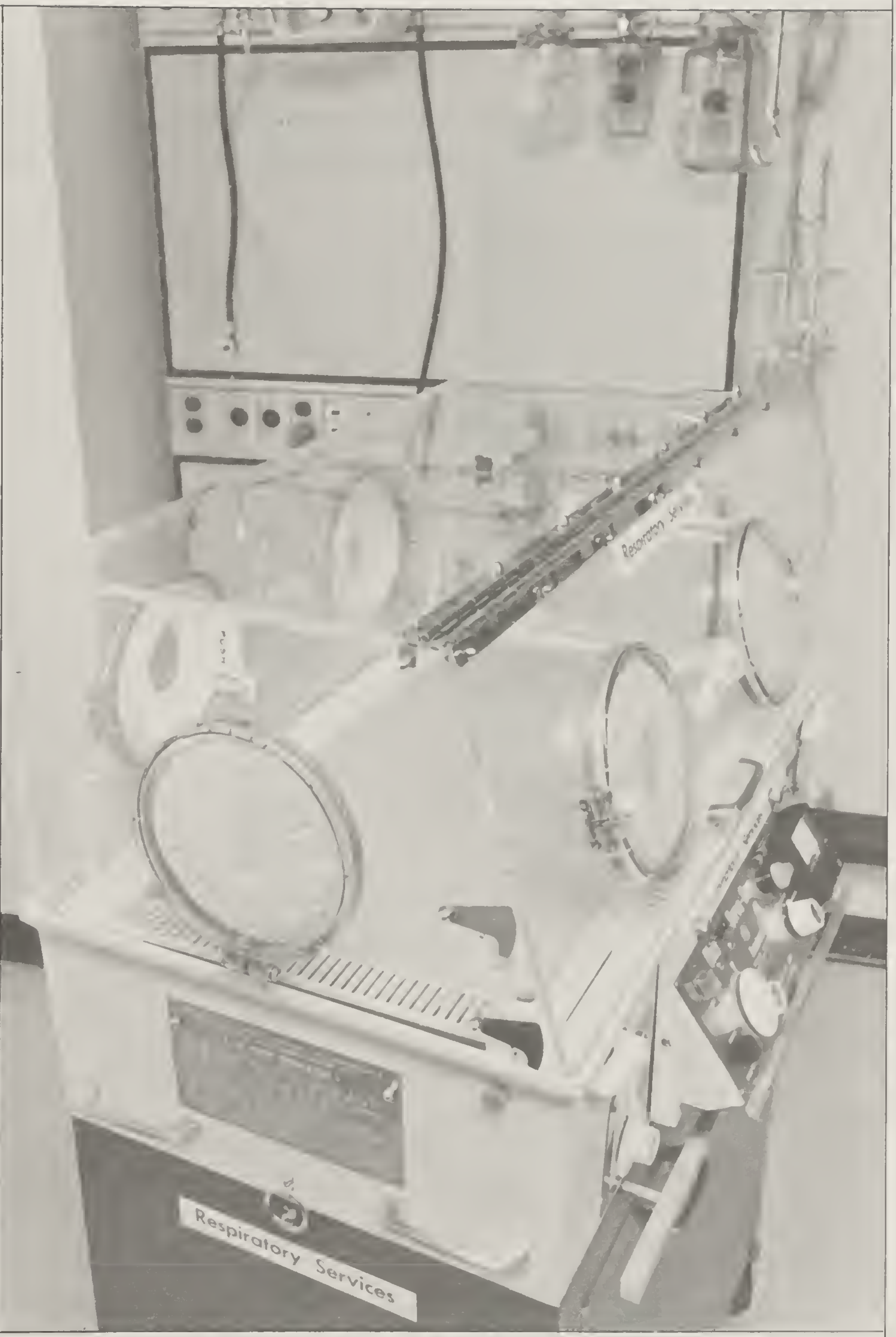
Objective four—improving the state's capacity to understand the infant mortality problem—will be met through several measures to improve systems for collecting, analyzing, and disseminating data on infant health and mortality and by conducting special studies of:

- minority attitudes concerning reproductive health practices;
- why women do or do not seek prenatal care, the use of walk-in centers for prenatal care, and the use of unlicensed pregnancy services (e.g., lay midwives);

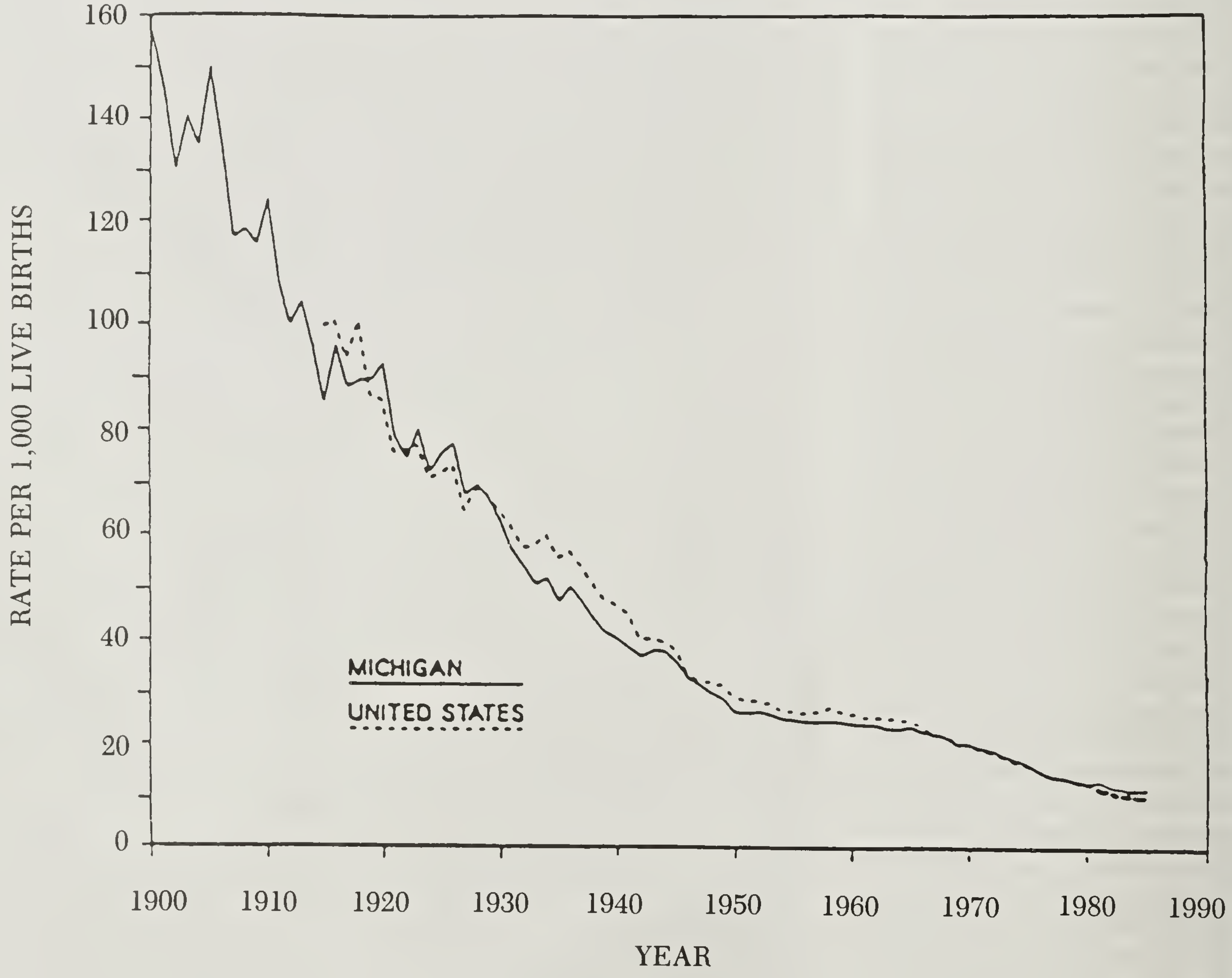
- alternative approaches to prenatal care;
- health care provider availability by region and provider willingness to accept Medicaid and PPC patients, and
- the regional distribution of specialized pregnancy and newborn care services.

If fully implemented, the five-year plan will substantially reduce Michigan's infant mortality rate and, at the same time, improve the health of the state's mothers and infants. In addition to the five-year plan, the task force developed supplementary recommendations that would further contribute to reducing Michigan's infant mortality rate. The task force also recommends formation of an advisory body to the governor's Human Services Cabinet Council. This group would oversee implementation of the five-year plan and evaluate each program after two years of operation.

Carrying out the plan will require commitment, perseverance and the cooperative efforts of several state agencies. Although a great deal is known about the problem of infant mortality, it is clear that there are no final or easy answers. We will never be able to eliminate infant mortality entirely, but the rewards of our commitment to do as much as possible will be great, for the lives and health of our children are our greatest resources. ☐



Michigan infant mortality rates, 1900-85, and U.S. infant mortality rates, 1915-85



SOURCE: "Michigan Health Statistics Annual, 1984" with 1985 data added (Lansing, Mich.: Michigan Department of Public Health), p. 256; Office of the State Registrar and Center for Health Statistics, Michigan Department of Public Health.

Average annual county infant mortality rates, 1983-85

County	Average Annual Infant Mortality Rate, 1983-85	Total Number of Infant Deaths, 1983-85	Total Black Infant Deaths, 1983-85	County	Average Annual Infant Mortality Rate, 1983-85	Total Number of Infant Deaths, 1983-85	Total Black Infant Deaths, 1983-85
Alcona	12.0	4	0	Lake	14.9	5	1
Alger	5.7	2	0	Lapeer	12.3	38	0
Allegan	8.5	35	1	Leelanau	6.4	4	0
Alpena	7.2	9	0	Lenawee	7.2	28	2
Antrim	5.5	4	0	Livingston	6.4	27	0
Arenac	7.8	5	0	Luce	16.1	4	0
Baraga	0.0	0	0	Mackinac	14.4	6	0
Barry	12.1	25	0	Macomb	9.9	272	13
Bay	10.5	53	0	Manistee	12.5	10	0
Benzie	6.1	3	0	Marquette	9.0	32	3
Berrien	13.8	103	49	Mason	14.1	15	0
Branch	10.9	21	0	Mecosta	11.0	15	0
Calhoun	13.2	78	21	Menominee	8.1	9	0
Cass	13.5	26	8	Midland	7.6	25	0
Charlevoix	14.6	14	0	Missaukee	5.3	3	0
Cheboygan	7.5	7	0	Monroe	8.3	46	4
Chippewa	8.6	10	0	Montcalm	9.4	22	0
Clare	19.5	21	0	Montmorency	6.5	2	0
Clinton	6.9	17	0	Muskegon	9.4	73	22
Crawford	5.8	3	0	Newaygo	7.3	13	1
Delta	9.1	15	0	Oakland	10.0	416	63
Dickinson	7.1	8	0	Oceana	6.2	7	0
Eaton	10.6	40	1	Ogemaw	3.9	3	0
Emmet	7.1	8	0	Ontonagon	3.0	1	0
Genesee	13.4	269	111	Osceola	4.4	4	0
Gladwin	12.3	11	0	Oscoda	2.9	1	0
Gogebic	7.9	5	0	Otsego	6.6	5	0
Grand Traverse	9.0	25	0	Ottawa	6.9	58	0
Gratiot	17.7	31	0	Presque Isle	12.8	7	0
Hillsdale	11.8	22	0	Roscommon	4.7	3	0
Houghton	8.3	12	0	Saginaw	15.3	153	68
Huron	8.0	13	0	St. Clair	11.2	69	4
Ingham	10.9	143	32	St. Joseph	9.9	28	2
Ionia	11.3	30	0	Sanilac	4.5	8	0
Iosco	9.0	16	0	Schoolcraft	2.9	1	0
Iron	10.6	5	0	Shiawassee	8.2	25	0
Isabella	8.4	18	0	Tuscola	9.6	23	0
Jackson	11.4	70	13	Van Buren	12.7	39	6
Kalamazoo	13.4	126	32	Washtenaw	10.5	121	30
Kalkaska	12.5	8	0	Wayne	15.6	1544	1008
Kent	9.4	241	61	Wexford	13.2	16	0
Keweenaw	30.8	2	0	OVERALL	11.7	4,739	1,556

SOURCE: Michigan Department of Public Health, Office of the State Registrar and Center for Health Statistics.

Reducing infant mortality: difficult decisions

By Robert P. Lorenz, MD

Michigan's infant mortality rate (11.7 deaths before age one per 1,000 live births in 1984) is higher than 42 of the 50 states. Before 1960, Michigan's infant mortality was better than the national average, but it has progressively worsened since then. Eighteen nations have an infant mortality rate lower than Michigan's. These disturbing statistics compelled Governor Blanchard to direct the Michigan Department of Public Health to assemble an Infant Mortality Task Force to submit recommendations to address this problem. Critical questions are: Why? What can be done? What should doctors do about it?

Eighteen nations have an infant mortality rate lower than Michigan's.

Why?

Low birthweight (less than 2,500 gm. or 5 lb. 8 oz.) is the strongest predictor of infant mortality. Two-thirds of all deaths occur in this 15 percent of our newborns. Infants weighing less than 2,500 gm. have a 3.5 relative risk of mortality compared to normal-weight infants; for those weighing less than 1,500 gm., the relative risk is 100! While the US rightfully boasts superb neonatal intensive care unit survival statistics in major centers, the problem is that in the US and in Michigan we have more of these small babies than other countries do. We need to do more to prevent low birthweight.

Infant mortality and low birth-weight rates are higher for populations that are poor and those with a low rate of education. They are higher for teenage mothers, for women with unwanted pregnancies, and for women with inadequate prenatal care, poor nutrition, substance abuse and poor support systems.

What can be done?

The Infant Mortality Task Force is considering an increase of $112 million in funding over five years. Whether that funding will be approved is uncertain. Under study are plans for improving access to prenatal care; increasing Medicaid reimbursement for obstetrics; paying labor and delivery physician fees in the Prenatal and Postpartum Care program; broadening services for women at high risk for medical, nutritional and psychosocial problems; improving preconception and pregnancy health education; increasing adolescent health education, and regionalization of pregnancy services. In pilot programs for young, indigent pregnant women, provision of comprehensive pregnancy care through such approaches does improve outcome. Such programs are cost effective. It has been estimated that $1 spent on prenatal care can save $6 in reduced neonatal care costs.

Teenage mothers suffer from lost educational and job opportunities, lost time for normal growth and development, disrupted homes and often poor parenting skills, and their children are at risk as well. Early and frank health education in schools, including sex education and family planning, reduce unwanted teen pregnancies as has been demonstrated in pilot programs in this state and across the country. These programs reduce infant mortality and low birthweight rates. But many parents and school boards resist sex education and family planning programs in the schools, thinking that such services encourage early sex. This belief is not supported by actual experience, as has been shown recently by the National Science Foundation. Although it is illegal to provide birth control devices in schools in this state, dispensing information about

Doctor Lorenz is a member of the Task Force on Infant Mortality representing the Michigan Section of ACOG. This article is reprinted with permission from the *Bulletin* of the Oakland County Medical Society, April, 1987.

amily planning in schools is allowed. However, many schools do not provide such information. If we want to reduce the epidemic of "children having children," we have the tools to do it. Is there resolve? Difficult decisions.

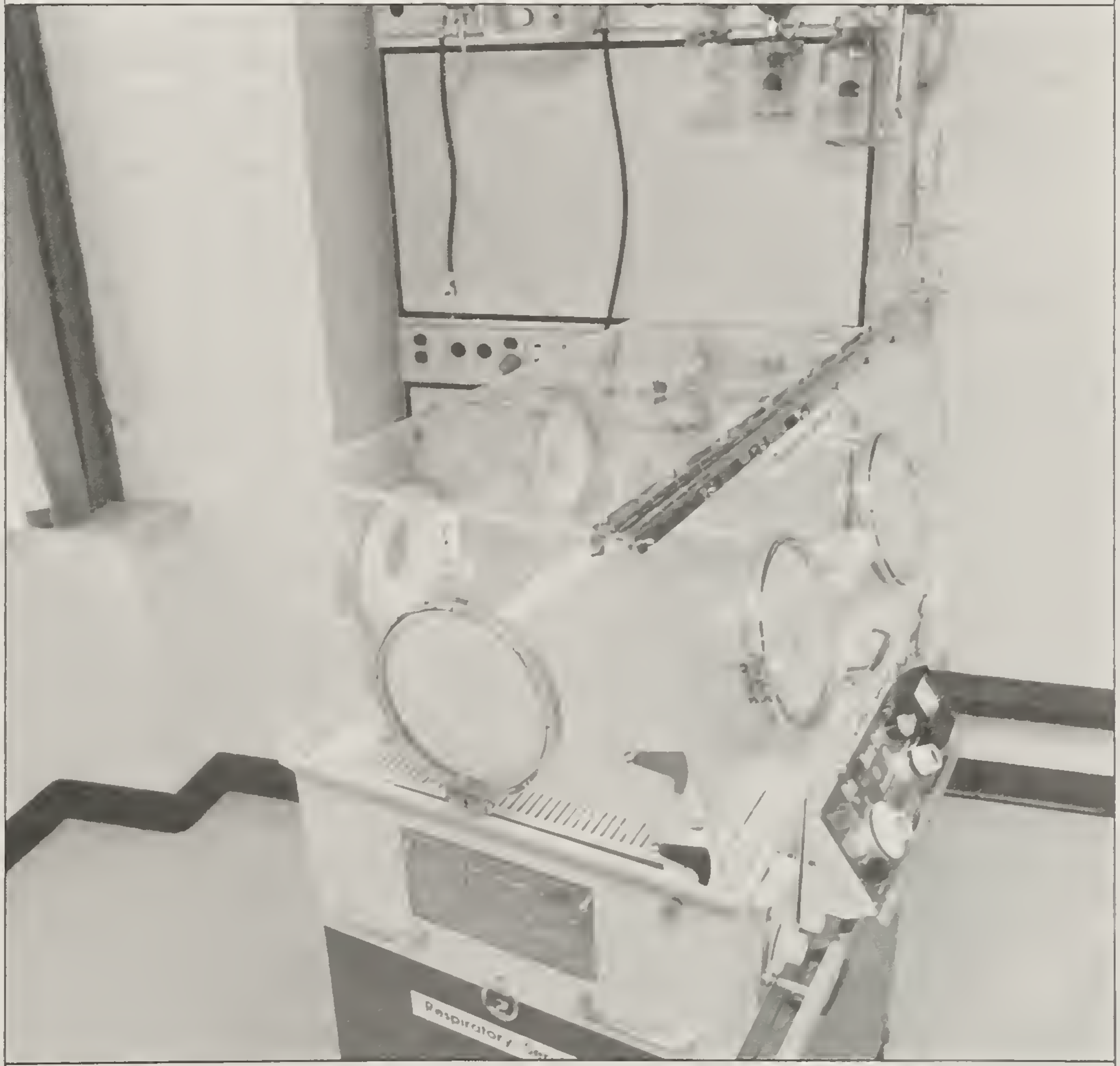
One hundred twelve million dollars over five years seems like a lot of money. It has been said that a society can be judged by how it cares for its children. The proposed state budget, by comparision, earmarks an increase of approximately $900 million over three years for improving prisons. Priorities? Difficult decisions.

From a public health perspective, the issue of legal abortion as a factor in improving infant mortality rates is important. Due to the current controversy surrounding Medicaid funding for abortion, the Infant Mortality Task Force did not comment in their report. Nevertheless, the experience in other states and other countries clearly demonstrates that restricting legal abortion results in a rise in infant mortality, as well as a marked increase in women's morbidity and mortality due to criminal abortion. The legislators and the public need to realize that a public health policy restricting legal abortion will have a public health result of increasing infant mortality rates. Difficult decisions.

What can doctors do?

The word "doctor" derives from the Latin verb *docere*, to teach. In a setting of difficult decisions regarding infant mortality, physicians as citizens and leaders should be resources for educating our legislators and our lay neighbors about the significance of problem and the complex alternatives we are faced with. Teenagers and infants don't vote, and legislators often seem more concerned with diseases they have than with what their grandchildren may have. Doctors need to be advocates of restructuring government priorities to increase maternal and child health budgets; they need to be advocates of appropriate sex education and family planning to stem the epidemic of "children having children," and to be advocates of reason in the complex issue of abortion and its relationship to other public health concerns.

Difficult decisions, but important work. ☐



New light shed on intrapartum asphyxia and brain damage

By Ruthmarie Shea-Atallah, BS, MA

“A whole web of information has been gathered . . . that will make it possible to end the malpractice crisis as we know it. Now.“ stated Richard L. Naeye, MD, at the 26th Annual Michigan Conference on Maternal and Perinatal Health held March 25 and 26 at the Hyatt Regency in Dearborn. “Preparing for the 90s: Controversies in Care”, established a hard line defense posture for physicians vulnerable to malpractice claims concerning long term neurological impairment, allegedly stemming from events occuring during labor and delivery.

Doctor Naeye, professor and chairman, Department of Pathology, Pennsylvania State University School of Medicine, Hershey, remarked, “What an historic occasion it is today—to be here together, talking about the same thing, with an *enormous amount of concurrence*.

“Significant progress has been made in the last two to three years in determining the underlying causes of brain damage. We will know which cases deserve to be compensated, because there has been true injury related to the management of the case. Other cases will *clearly* be injury or maldevelopment outside the control of the health care delivery system,” said Doctor Naeye.

It has been commonly assumed that brain damage is largely the result of fetal hypoxia during the period of labor and delivery and, as such, is a factor over which the physician has control and responsibility.

> **“Intrapartum asphyxia is the result of fetal brain damage rather than the cause.”**

“The roots of the malpractice crisis lie in a misinterpretation of scientific data. Assuming a casual relationship from associations is the main problem.” Doctor Naeye constructs the following syllogism to illustrate how faulty reasoning lead to conventional wisdom:

- Many children with cerebral palsy have a history of fetal distress.
- Most fetal distress is due to hypoxia.
- Therefore, most cerebral palsy is due to hypoxia.

“Scientific evidence provides an alternate explanation, which is in fact the true explanation. That is, in already damaged brains the stress of normal delivery potentiates malfunction, which then manifests itself as fetal distress,” states Doctor Naeye.

Kenneth Niswander, MD, concurs. “Intrapartum asphyxia is the *result* of fetal brain damage rather than the cause.” Doctor Niswander, professor, Department of Obstetrics and Gynecology, University of California at Davis, Sacramento, stresses that “Very few, of even severely asphyxiated babies, end up with brain damage.”

“A low Apgar score does not mean asphyxia,” states Alfred Brann, MD, Professor of pediatrics, director of neonatal-perinatal medicine, Emory University School of Medicine, Atlanta.

“Forty three percent of babies with an Apgar of 0-3 at 20 minutes will survive *without* central nervous system damage.” Doctor Brann resuscitates these newborns for one hour. Until other causes of low Apgar can be ruled out, Doctor Brann uses the term ‘fetal depression.’ “One has to have criteria to use the term ‘asphyxia” on the chart:

$\downarrow pO_2$ $\uparrow pCO_2$ $pH < 7.25$

Asphyxia sufficient to cause brain damage will result in very severe, likely fatal, damage to other organs as well. It is very, very difficult to get hypoxia damaged brains and still get survival. Very difficult indeed.”

“A CNS damaged infant is going to show signs *within the first week of life, generally within the first twelve hours*.” Doctor Brann dismisses the notion of intrapartal hypoxic episodes affecting

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The author, Ms. Shea-Atallah is a Detroit area freelance science writer.

earning disorders and vague hyperactivity states in children. "The data does not support it."

According to Doctor Naeye, a pathologist, when severe acute intrapartum hypoxia does occur, the outcome is usually stillbirth or neonatal death. If the infant is near term, cerebral edema will likely be visible on physical examination. An echo will document the findings. The patient will:

- be comatose
- be obtunded
- be stuporous with recurrent apnea for at least several days
- 92 percent will have renal failure, evidenced by low or absent urinary output by the second or third day
- have high blood urea and presence of creatinine
- 50 percent of the time will have cardiac enlargement and occasional elevation of cardiac enzymes
- sometimes there is liver failure with enzyme elevation and increased number of recurring seizures.

If the child survives such complications, one would expect severe mental retardation with spastic quadriplegia. Prolonged hospitalization and increased death rate in the first year of life are characteristic. Factors known to be associated with acute intrapartal hypoxia or asphyxia were analyzed in the Collaborative Perinatal Study conducted by Doctor Naeye and associates.

Retrospective analysis of 60,000 children who had suffered from acute hypoxic episodes revealed that these did not correlate with long term neurological impairment. Neurological impairments are defined as one or more abnormality of vision, hearing, cranial nerve function, fine or gross motor ability position sense, reflexes, sensation, and speech production.

No correlation

Although the subject of many malpractice claims, no correlation was found between long term impairment and such factors as maternal shock, abruptio placenta, placenta previa, vaginal bleeding at delivery, low maternal weight gain, cord around the neck, cord prolapse, and acute fetal blood loss. However a strong correlation was found between maternal hypertension, alcohol consumption, drug use, maternal seizures and low maternal IQ. In a subgroup of mothers who had low body weight prior to pregnancy and low systemic pressure, a very strong correlation with long term impairment was found. These mothers with low blood volume and third trimester BP drop failed to achieve adequate hemodilution and were at high risk for impaired newborns.

Delivery factors such as skull fractures, high forceps, gas anesthesia, oxytocin administration, tumultuous labor, persistent high uterine tone, prolonged labor and arrested progress of active labor failed to correlate with long term neurological impairment.

Continued on next page

BRAIN DAMAGE/Continued

"Death, yes", states Doctor Naeye, "but none of these factors was associated with any excess of long term neurological impairment. These are the subjects of most malpractice suits."

Fetal growth parameters are highly predictive of long term impairment. Abnormalities in head circumference, weight, length and umbilical cord all have a very strong association with long term neurologic impairment. "I cannot overemphasize the importance of taking careful measurements of the newborn infant. You must know whether the child was growth retarded or not. These will help you if you get into a claim of malpractice."

"Meconium in the amniotic fluid, chronic intrauterine hypoxia, even low Apgar scores are *only* associated with long term neurological impairment *if growth retardation also is present*," states Doctor Naeye.

Placental examination is an essential factor in establishing when an insult or injury occured. A fetus who has suffered during pregnancy from chronic low uteroplacental blood flow will not be salvaged by an emergency C-section. Edematous chorionic villi in the placenta will indicate that the fetus has been hyperfused for at least several days or even weeks prior to delivery. "In the overwhelming majority of infants born prior to 25 weeks of gestation, survival can be predicted based on the amount of edema in the placenta." Doctor Naeye has developed a protocol for placental examination which is available on request.

"The final and best solution to the malpractice crisis is finding out the scientific truth," states Doctor Naeye. Doctor Niswander comments, "The burden of proof already has shifted to those who insist on the conventional views."□

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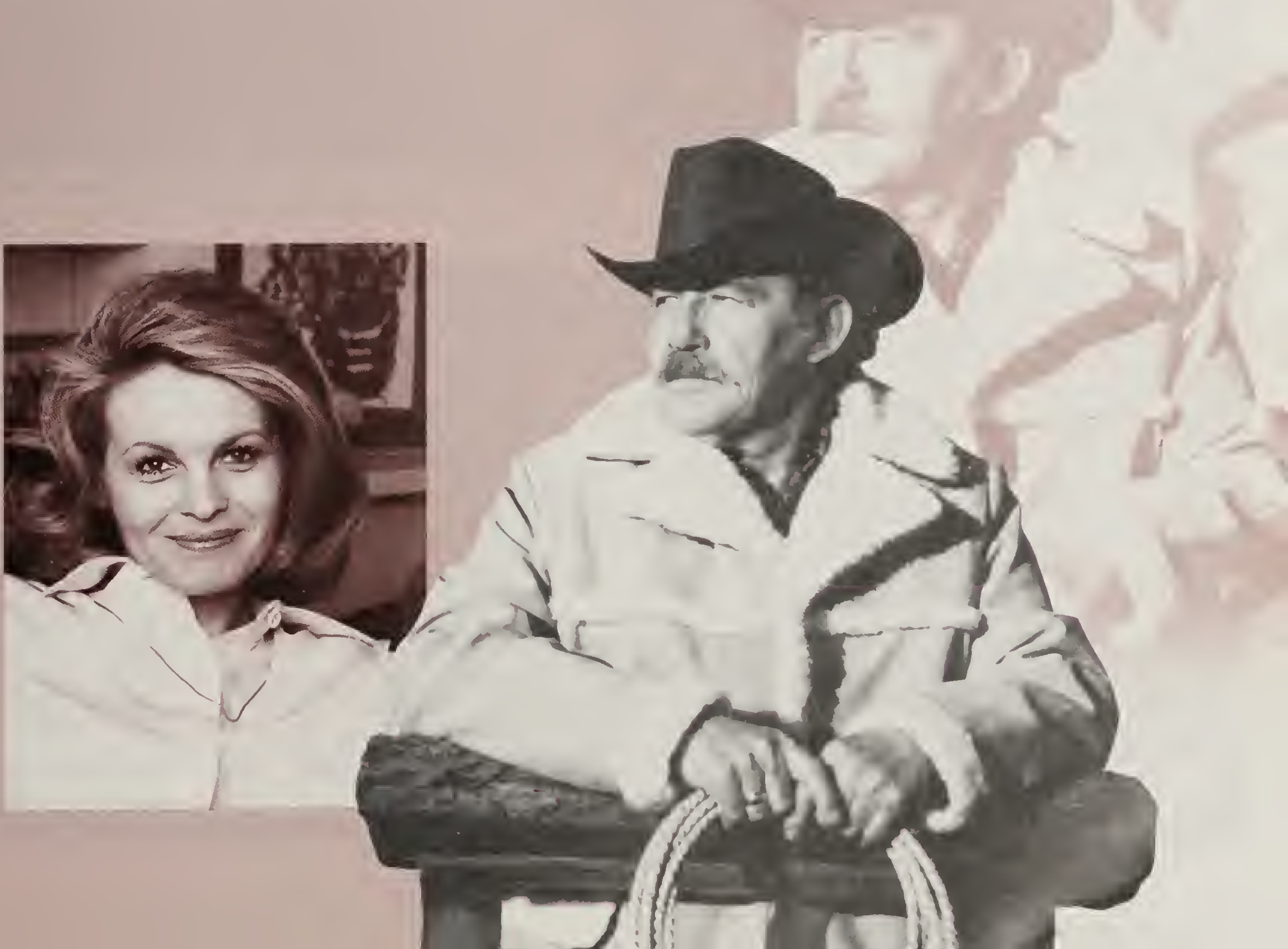

MSMS House of Delegates convened April 24-26

A color guard graced the opening ceremonies.

Then MSMS President Thomas Berglund, MD, second from right, watches the proceedings surrounded by his family.

AMA President and Port Huron physician John Coury, MD, facing camera, was a special guest. Frank Walker, MD, right, is head of the MSMS delegation to the AMA.

AMA President-elect William S. Hotchkiss, MD, Virginia, greeted the MSMS delegates.

Richard J. McMurray, MD, left, MSMS past president and former head of the Michigan delegation to the AMA, accepts the delegates' thanks for his dedicated and continuing service at the national level. Doctor Walker looks on.

Above left: Some business of the delegates takes place during casual hallway meetings. Pictured here, left to right, are Philip Manno, MD, Carl A. Gagliardi, MD, MSMS president, and Busharat Ahmad, MD. *Above right:* MSMS Delegate Gilbert Bluhm, MD, testifies before the full House. *Lower right:* Reference committees analyze and recommend action upon resolutions.

New MSMS President Carl A. Gagliardi, MD, Dearborn, takes the oath of office from MSMS Secretary Robert Leitch, MD, then accepts a chain ncluding MSMS presidents' names from Immediate Past President Thomas Berglund, MD.

MSMS
MANDELL

The delegates elected Frederick W. Bryant, MD, left, Royal Oak ophthalmologist, MSMS president-elect.

Senator John J. H. Schwarz, MD, (R-Battle Creek) urged his fellow physicians to consider public service. He spoke during the MDPAC Annual Luncheon held during the three-day meeting.

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Rep. Paul Hillegonds, House minority leader, (R-Holland) told MDPAC members that Republican lawmakers have turned around their "minority mentality" and have become more issue-oriented.

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Charles L. Oppy, MD receives the Plessner Memorial Award

Michigan State Medical Society
MS

Doctor Oppy, left, accepts the Plessner Award from MSMS Board Chairman Robert Paxton, MD.

Charles Oppy, MD, Roscommon general practitioner, was presented the Plessner Memorial Award May 25 at the Amway Grand Plaza Hotel, Grand Rapids, during the 1987 MSMS House of Delegates Meeting. The following article was written by his colleagues in the Medical Society of the North Central Michigan Counties, and was published in area newspapers.

The Michigan State Medical Society at its annual meeting of the House of Delegates honored Charles L. Oppy, MD, who "best exemplifies the practice and ethics of a rural country practitioner."

Doctor Oppy's contributions to Michigan State Medical Society over the years have been numerous and outstanding—however, this is *not* why he was named recipient of this award. The Plessner Award is not given as recognition of services to organized medicine.

Some background

Frederick Plessner's idol was his grandfather, a mid 19th Century country doctor who regaled his grandson with stories of his life as a country doctor traveling in his horse and buggy throughout rural Michigan. Mr. Plessner wanted to pay tribute to his grandfather's memory by giving the Michigan State Medical Society an opportunity to honor those country doctors who have dedicated their lives to their patients and given unselfishly to their communities.

Using Roscommon as the center and drawing a circle to include Grayling, Mio, St. Helen, West Branch, Houghton and Higgins Lake maps out "Oppy" country.

Almost every family within this circle bears the "Oppy" brand—birth certificates, marriage licenses, death certificates. As the school physician, Doctor Oppy has cared for generations of atheletes in the packed, sweaty gyms or on the snowcovered football fields. As medical examiner, he works closely with law enforcement agencies and the courts. As a friend, counselor and civic advocate, his work with the Chamber of Commerce, with the new nursing home of which he will be medical director, and with the American Cancer Society stand out.

Most enduring of his contributions will be his work as a founding Board Member of Kirtland Community College.

The area surrounding Roscommon has many natural resources: the best trout stream; beautiful lakes and forests; the best tasting drinking water, and an ideal climate. But, by far, over the years its best natural resource has been Charley Oppy, MD—physician extraordinaire. ☐

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CON program undergoing needed reform

By Raj M. Weiner

The following article is excerpted from Ms. Wiener's presentation at the April 9 MSMS Critical Issues forum in Grand Rapids.

I'm sure the subject of interest to most of you is the certificate of need (CON) process. First, let me begin by saying that I have not met anyone in Michigan who does not believe the program needs a comprehensive overhaul. The law that we operate under was written in 1978 and was piggybacked on the federal planning law which has since been repealed. When the law was written, the program was designed to achieve three goals: to contain costs, to preserve quality of care and to promote access to care.

Although these goals are laudable and certainly still desirable, the legislative mechanism for their achievement is outdated, principally because it has not kept pace with the dramatic changes occurring in this industry. In addition, the implementation of the law has been further complicated by a court ruling, the Huron Valley decision, which requires competitive comparative reviews of applications.

When the law was written in 1978, these reviews were never contemplated. Thus we now conduct them under a law that made no provision for them. Michigan is the only state conducting these reviews. No other state gives legal precedence to the Huron Valley case. However, we must adhere to it here.

> **"It is my hope. . .we will be able to do away with comparative reviews for most projects."**

I'm sure many of you are aware that the Department is now in the process of promulgating rules to exempt replacement equipment from comparative review.

Public hearings on these rules were held April 6, 1987. If we are successful in getting these rules passed, replacement of existing equipment meeting an existing need within a licensed facility will no longer be subject to comparative reviews.

It is my hope that through comprehensive reform of the CON program, we will be able to do away with comparative reviews for most types of projects. To accomplish this, however, we will need both your support and cooperation.

Background

Time has also become a highly controversial issue with the CON program. Before addressing it, however, I think it is appropriate to give you a little background on how the program operates. The Construction Division is responsible for reviewing applications. Last year they reviewed 377 CON applications involving about $665,000 in proposed capital expenditures. This was a 59 percent increase in the number of applications reviewed as compared to the calendar year 1985.

During this same period, the average length of time required for the review applications was reduced from 127 days overall to 118 days in length. This may seem strange given that many of you have heard that it takes 238 days or more to review an applications. I would like to clarify that for you.

The time from which an application is completed to the time a decision is rendered by the Department takes an average of about 118 days. As you know, in comparative reviews, there are winners and there are losers. The applications that are disapproved, appeal. Once an appeal is in progress, the department has to withhold the CON even from those who were approved until the legal process is over. Once we are engaged in lengthy administrative processes and legal battles, there is a long, drawn out period during which service, whether it be lithotripters, MRIs or any other type of new service, is withheld from the community.

One of the challenges that is before us is to find the proper balance between the right of each individual facility to compete and the needs of the public which must be served.

We took significant steps in

Continued on page 387

Ms. Wiener is chief, Bureau of Health Facilities, Michigan Department of Public Health.

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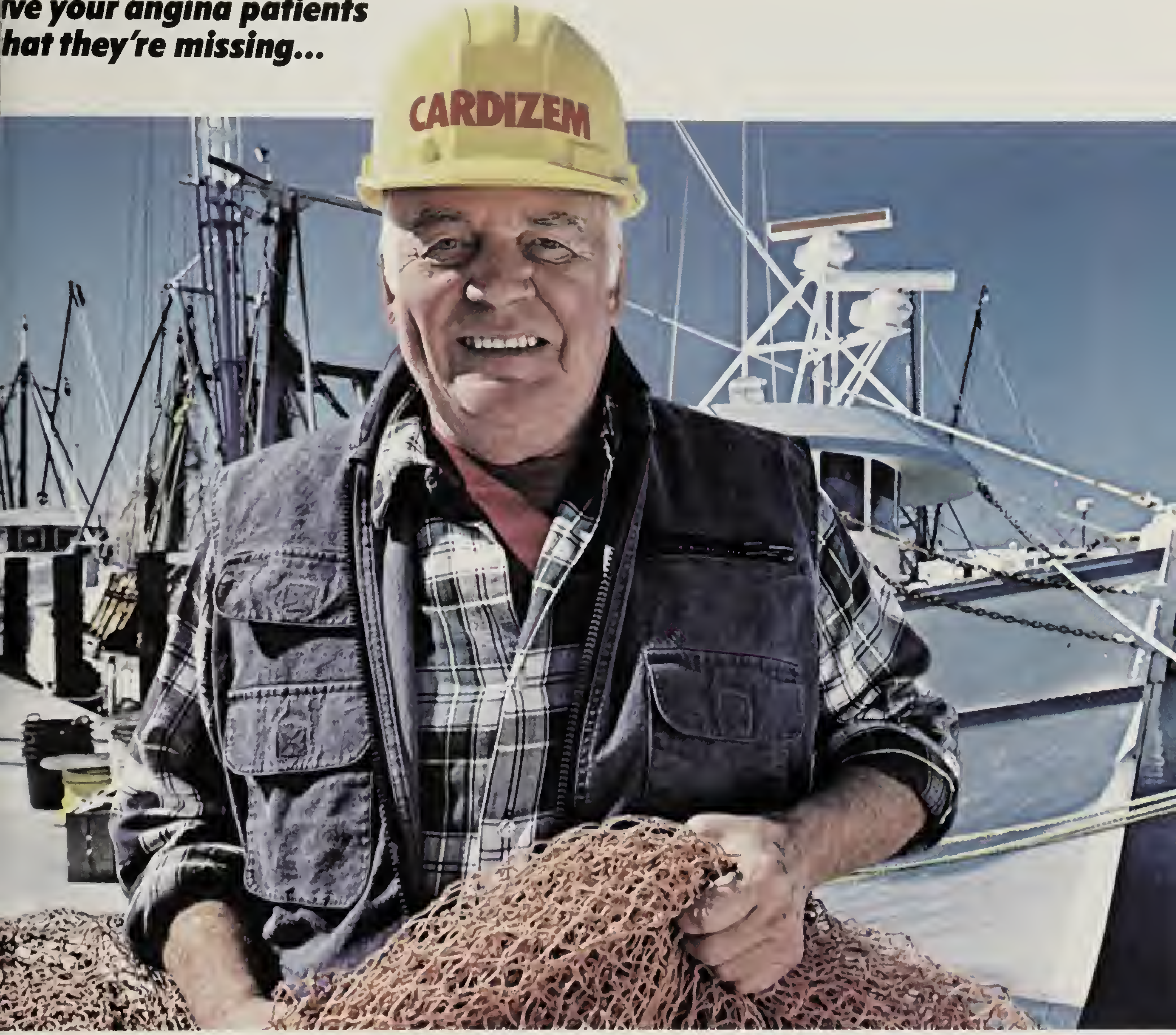

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WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt).
   Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Petechiae, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

Issued 7/86

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1986 to improve the legal and administrative framework of the CON program to avoid legal delays. These steps included first, the promulgation of emergency and then permanent CON rules to provide a strong statutory basis for the program. These rules set out the criteria by which applications are reviewed, particularly comparative reviews. It was a major effort to get the rules promulgated but we did it with the cooperation and support of providers, consumers and purchasers who realized that rules were necessary to make the decision-making process at the department fair, consistent and timely.

Non-substantive review

In addition, we have initiated a non-substantive review process. One which will expedite reviews for such things as facility renovations, parking lots, elevators, energy conservation projects. Things that we believe we should not be making the industry jump through hoops on. Nevertheless, under the law, we are required to review these projects. To further expedite the process, we have developed a new nine page application which is easier to complete. The turn around time for non-substantive project review is less than 45 days.

We also made major revisions in the State Medical Facilities Plan to provide criteria for the applications review. We have also initiated publication of a monthly CON newsletter. This newsletter provides current statistics on the level of activities and performance of the program as well as information that we think is important.

Successfully navigating the administrative rule making process depended on the cooperation of many, including health care purchasers, providers, seniors and consumers. Because our collaborative effort was successful, we have adopted this approach for our comprehensive review and overhaul of the CON program. In June of last year, we created an executive branch work group, chaired by myself and Patience Drake, director of the Office of Health and Medical Affairs. The group is now reviewing the entire statutory framework governing the CON program. Our objective is to update and streamline Michigan's health planning and CON statutes.

Originally, this review was to have been completed in July, however the legislative debate on the subject began recently. We are expediting our process to allow the legislature an opportunity to benefit from it by having a comprehensive plan in front of them before they begin looking at the issues.

Areas of concentration

Some of the areas that we are concentrating on are the program's scope, implacability, review procedures, thresholds, enforcement provisions and the appeals process. We hope to especially concentrate on the dissemination of new technology. Currently we are using the same methodology for new technology that we use for bricks and mortar and we find that it does not work. Lithotripters is the example that everybody remembers. At every step along the way we learned something and we do not want to repeat our mistakes.

As you know, Senate Bill 64 has passed the Senate. Commonly known as the Threshold Bill, the bill raises the capital expenditure threshold from $150,000 to $1.5 million. In addition, the threshold for change of service review is modified to require review only of those clinically related services which require annual operating costs in excess of $306,750. The bill also eliminates review of a proposed reorganization of clinical services and adds inflation indexes for the operating cost and capital cost thresholds. The bill is supported by both the Michigan Hospital Association and by the Michigan State Medical Society. I, however, oppose the bill in its current form and I want to explain why.

First, a capital threshold of $1.5 million is too high to assure that large projects are not divided into component parts for the purpose of avoiding review. Second, raising the CON threshold does not automatically raise the federal threshold under Section 1122. Currently, the Section 1122 threshold is $600,000 and federal reviews might still be required for projects between $600,000 and $1.5 million. If the federal Sec-

Continued on next page

tion 1122 threshold is significantly below the state CON threshold, the Department will be forced to consider discontinuing Section 1122 reviews altogether because there is no federal reimbursement to the Department for the cost of those reviews. The Section 1122 reviews currently conducted by the Department would likely be taken over by the federal government in Washington or Chicago.

I also have concerns with Senate Bill 64's impact on the definition of "change in service." Tying "change in service" reviews to an arbitrary dollar operating cost threshold adds a further complication to CON. Not only will it be hard to predict the future impact of a new service on operating costs, it will be impossible for the department to independently verify, monitor or enforce those predictions. In many cases, new services should be subject to review regardless of their operating costs because of their impact on quality or access. In such cases, SB 64 may reward those facilities who are inaccurate in their cost accounting or who cut costs through inappropriate reductions in quality. While the current definition of "change of service" must be revised, I do not think the broad exemptions proposed by SB 64 are in the public interest.

If SB 64 is enacted as it currently is written the administration of the program would be unpredictable and unenforceable. We would be forced to rely on data which is unverifable. None of these changes would promote a program which is fair, consistent and predictable, goals I think we all share.

Expert recommendations

The planning process is essential to the operation of the CON program. The Department of Public Health convenes a group of experts to sit down and recommend planning policies. These policies are meant to look at the issues of cost, access and quality. The group decides what quality assurance we need in the dissemination of new technology. They develop a need methodology to determine how many of a particular type of equipment are needed in the state to serve the population that would use it.

The planning policies are then submitted to the legislature and the public for a 60 day public comment period. Once that is over, they are sent to the Statewide Health Coordinating Council which is required to review them. If approved, they are binding on the Michigan Department of Public Health and on the CON program. So for example, when the experts decided that three lithothripters were enough to serve the needs of the state the CON Unit could approve only three applications, even though we had ten applications in the competitive comparative review.

Although we have been pleased with the expert group model as a way to formulate recommendations, we have been concerned with the application of planning methodologies which limit the number of services in any geographic region. In response, we are proposing to move to a methodology which relies on actual hospital case mix and discharge data.

The success of our being able to make this move will depend on our ability to get hospital-specific data. I recognize that hospitals feel the need to protect their privacy on some of these issues. However, access to this information is critical if we are to effectively implement an alternative planning methodology. We haven't identified the right method yet, but we are exploring the alternatives related to our planning policies for MRIs. I am sure that if we all work together we can find a way to accomplish our goal.

Also, by shifting to a hospital-specific data base, we can concentrate more on achieving the other two goals of CON seldom mentioned: quality of care and access. Cost containment is the third goal that has, to some extent, been met by the program. For example, out of the $655 million of proposed expenditures that we reviewed last year, $430 million were approved while $230 million in capital expenditures were disapproved. Given that capital expenditures are passed directly through, I believe

Continued on page 391

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(See Brief Summary of Prescribing Information on the next page.)

*Data on file, CIBA Pharmaceutical Co.

629-7750-A

Transderm-Nitro®
nitroglycerin
Transdermal Therapeutic System

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken A final evaluation of the effectiveness of the product will be announced by the FDA

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring

In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage When these symptoms occur, the dosage should be reduced or use of the product discontinued

Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea and vomiting These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued In some patients, dermatitis may occur

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone

The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs

Do not store above 86°F (30°C)

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

HOW SUPPLIED

Transderm-Nitro System Rated Release *in vivo*	Total Nitroglycerin in System	System Size	Carton Size
2.5 mg/24 hr	12.5 mg	5 cm²	30 Systems (NDC 0083-2025-26) *100 Systems (NDC 0083-2025-30)
5 mg/24 hr	25 mg	10 cm²	30 Systems (NDC 0083-2105-26) *100 Systems (NDC 0083-2105-30)
10 mg/24 hr	50 mg	20 cm²	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm²	30 Systems (NDC 0083-2115-26) *100 Systems (NDC 0083-2115-30)

*Hospital Pack 100's

C85-35 (Rev 11/85)

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA.

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C I B A

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September 24-26, 1987
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Michigan State University Family Practice Residency
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GOAL:

To bring together professionals in the disciplines of the humanities, medicine and social sciences to discuss the impact of AIDS on our society, along with appropriate responses of the medical education community.

OBJECTIVE:

To explore the past through literature, history and art for clues to the feelings and reactions of past generations to their own plagues, then use these insights to inform our current struggles with ourselves and with AIDS.

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302 Kensington Ave.
Flint, Michigan 48502

CON/Continued

the $230 million not approved resulted in direct savings to consumers.

Adversaries

Unfortunately, it is the drive to achieve the program's cost containment that has created such an adversarial relationship between providers and purchasers. The time has come, I think, to set aside this adversarial relationship. We need to work together to identify the right mix of competitive and regulatory strategies to make the system work effectively. In this regard, we either need to amend the CON program legislation to develop a program which is fair, predictable and most importantly, enforceable, assuring that good providers are not penalized by the process. If we cannot cooperate together to develop a strategy which effectively meets this objective, we need to seriously consider deregulation as an option, allowing purchasers to comparison shop.

The work group I spoke of earlier is our opportunity to initiate that collaborative effort. It is beginning to demonstrate the beginnings of cooperation among all parties. Everybody is affected by the high cost of health care and a great deal of professional control is required to make the system work. We have the opportunity right now to find the right mix. I am not convinced that the free market approach will work, but neither do I believe that massive government regulation will do the job. ☐

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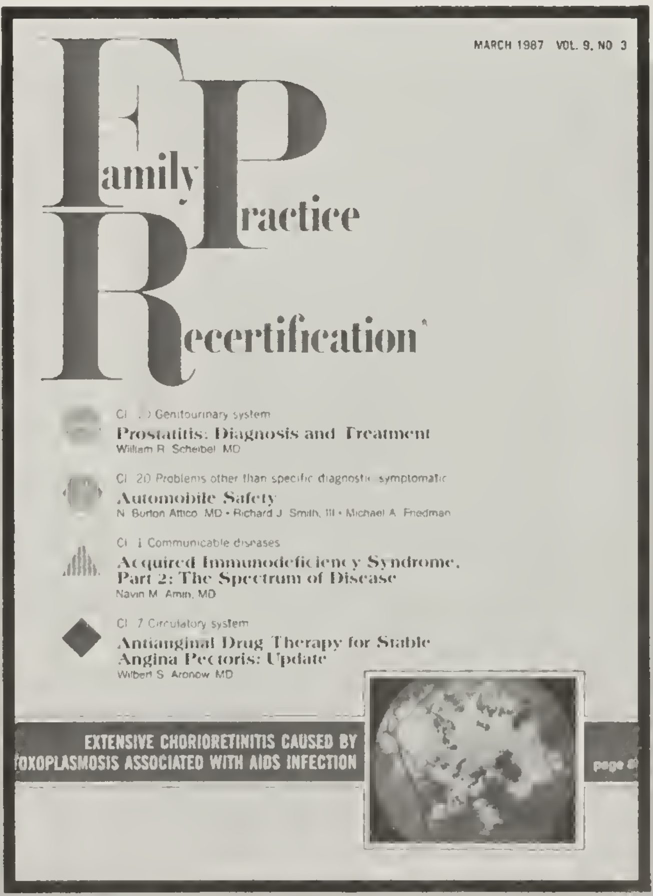

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Family Practice Recertification

Cl .) Genitourinary system
Prostatitis: Diagnosis and Treatment
William R Scheibel MD

Cl 20 Problems other than specific diagnostic symptomatic
Automobile Safety
N Burton Attico MD • Richard J Smith, III • Michael A Friedman

Cl 1 Communicable diseases
Acquired Immunodeficiency Syndrome, Part 2: The Spectrum of Disease
Navin M Amin, MD

Cl 7 Circulatory system
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Wilbert S Aronow MD

EXTENSIVE CHORIORETINITIS CAUSED BY TOXOPLASMOSIS ASSOCIATED WITH AIDS INFECTION

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PRACTICAL ▪ CLINICAL ▪ EDUCATIONAL ▪ CURRENT

Debating Michigan's future: health care in Michigan

A report by Public Sector Consultants, Inc.

The forces affecting future health care policy in Michigan will be shaped mainly by shifts in the age of the state's population and by the continuing struggle of both government and the private sector to constrain medical care spending without unduly limiting access to care.

Demographic shifts

By about forty years from now, in 2030, one of every five Americans will be 65 years old or older. Between now and then, the 85-and-older population will increase three to four times as fast as the general population. From 1980 to 1995 alone, the nursing home population is expected to grow from 1.2 million to 1.9 million; by 2040, 4.3 million elderly (65 and older) are expected to be institutionalized.

Michigan's population is slightly younger than the national average. About 11 percent of our state's people are age 65 or older; by 2020, this group will comprise 16 percent.

The elderly have higher rates of illness, injury and disability than does the general population; they need more medical services and their medical care is more intensive and prolonged. People over 65 years old use hospitals three and one-half times more often than do those under 65 and they are likely to stay in the hospital longer.

The most recent generation of Americans doubled the value placed on health care relative to all other societal needs.

The increase in the elderly population will stimulate demand for medical care in various specialties, increase the need for outpatient care and necessitate training more professionals in geriatrics and gerontology— expertise already in short supply according to a recent report from the US Department of Health and Human Services.

The aging of the population will also call for new and better ways to provide long-term care. Alternatives to institutional long-term care are needed to reduce dependence and unnecessary institutionalization. demand will increase sharply for social support services, such as home health care, personal care, specialized transportions, mental health programs and congregate housing.

Finally, while the aging of the population will increase the demand for medical care, there will be proportionally fewer younger and middle-aged people in the work force to support the costs of government and private insurance.

Costs and reimbursement of medical care

In 1984, 10.7 percent of US gross national product (GNP) was spent on health. In other industrialized nations the figures were:

- Sweden—9.4 percent
- West Germany—8.1 percent
- France—9.1 percent
- Netherlands—8.6 percent
- Canada—8.4 percent
- United Kingdom—5.9 percent

In 1985, US health care expenditures totaled about $425 billion, 10.6 percent of GNP. (In Michigan, an estimated $15-16 billion was spent in 1985.) By comparison, in 1960, national health care expenditures accounted for 5.3 percent of GNP. Thus, the most recent generation of Americans doubled the value placed on medical care relative to all other societal needs.

Where does the money go? Nationally, 39 percent of all health expenditures in 1985 were for hospital care; 19 percent for physicians' services; eight percent for nursing home care; eight percent for drugs; six percent for

Continued on page 394

Public Sector Consultants, Inc. issued this report as one in its series, "Debating Michigan's Future: Toward the Year 2000."

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FUTURE/Continued

administration. Public health activities consumed about three percent of all expenditures, construction of medical facilities about two percent and research about two percent.

Where do the dollars come from? The federal government (primarily through the Medicare and Medicaid programs) pays 29 percent of the total health bill. State and local governments contribute 12 percent. Private health insurance pays 31 percent. Patients pay 25 percent directly. Philanthropy and other sources account for the remaining three percent.

Financing long-term care services has already become a critical concern of health planners and policy makers. At present, the principal means of financing long-term nursing care for most older adults is through Medicaid. As a result, in Michigan and many other states, Medicaid has been the fastest growing budget item over the past ten years. Alternatives for financing long-term care must be found. Likely arrangements include medical IRAs, long-term care insurance, wider use of home-equity conversion and government-supported catastrophic health insurance programs.

Another area of concern to health policymakers is financing the health care for high-risk uninsured individuals, who number about 35 million nationwide. Legislation pending in Congress would require states to establish pools to provide comprehensive health care coverage for the uninsured. Some subsidization of medical expenses for the uninsureds is necessary; the major policy question will be who pays for the coverage—government and/or the private sector?

Improving personal health

Declining mortality has caused the world's population to expand. It took perhaps as many as one million years for the human population to reach one billion. The second billion was added in 100 years; the third in 30; the fourth in 15 and the fifth in 11. The modern rise in population resulted chiefly because better hygiene reduced infectious diseases; by the 20th century, immunization against and treatment of disease began to improve health significantly. The public became more confident in the ability of medical science to cure and prevent disease and more aware of the environmental and behavioral factors responsible for good health.

Because of its past success, medical science today plays a smaller role in good health and long life than one might imagine. According to Thomas McKeown, a Canadian health policy analyst, to be well, one must be born free of major congenital disease, be adequately fed and protected from hazards in the physicial environment and not smoke, overeat, or live a sedentary life. Today a person living in the United States has great influence on his or her state of health and, indeed, his or her life span. As medical science and technology chip away at morbidity (disease) and mortality rates, personal responsibility for good health continues to increase. One result of improved medical science is, frankly, its diminished consequentiality to good health. McKeown makes this point more bluntly:

> A moderate or heavy smoker would probably live longer by giving up smoking and giving up doctors than by retaining both.

John Knowles, a widely recognized authority in preventive health care, suggests that "the next major advances in the health of the American people will be determined by what the individual is willing to do for himself and society at large." Combined with progress in identifying disease earlier and in eliminating or reducing harmful environmental factors, behavioral changes such as reducing alcohol and cigarette use are expected to extend average life expectancy in the coming decades. Whereas a female born in Michigan in 1984 can expect to live 77 years, one born in the year 2000 may expect to live 90 years or longer.

Preventive health care is becoming increasingly important both as individuals seek to improve their lifestyles and as or-

Continued on page 399

CONFIRMED

CONFIRMED BY CLINICAL EVIDENCE

ZANTAC® 150 h.s.

ranitidine HCl/Glaxo 150 mg tablets

EFFECTIVE MAINTENANCE THERAPY

for healed duodenal ulcer patients

See last page for references and
Brief Summary of Product Information.

Glaxo/ROCHE

CONFIRMED

In two randomized, double-blind, and well-controlled clinical trials, ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

Percent of patients with observed duodenal ulcer recurrence

		0-4 months	0-8 months	0-12 months	No. patients
USA[1]	ranitidine 150 mg h.s.	9%	14%*	16%†	60
	cimetidine 400 mg h.s.	23%	34%	43%	66
UK, Ireland, Australia[2]	ranitidine 150 mg h.s.	8%‡	14%‡	23%‡	243
	cimetidine 400 mg h.s.	21%	34%	37%	241

*p=0.02
†p=0.01
‡p≤0.004
%=life-table estimates
All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Convenient once-a-night dose with a low incidence of side effects[3]

Headache, sometimes severe, seems to be related to ranitidine administration. Other side effects have been reported; for a complete listing, see the **ADVERSE REACTIONS** section in the Brief Summary.

No significant interference with the hepatic cytochrome P-450 enzyme system at recommended doses

ZANTAC 150 mg has no significant drug interactions with theophylline, phenytoin, or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications that decrease gastric acidity are administered.

Zantac® 150

ranitidine HCl/Glaxo *150 mg tablets*

One tablet at bedtime
for maintenance

See next page for references and
Brief Summary of Product Information.

Glaxo/ROCHE®

CONFIRMED

Zantac® 150

ranitidine HCl/Glaxo *150 mg tablets*

One tablet at bedtime for maintenance therapy in healed duodenal ulcer patients

References:

1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.
3. Data available on request, Glaxo Inc.

ZANTAC® 150 Tablets
(ranitidine hydrochloride)
ZANTAC® 300 Tablets
(ranitidine hydrochloride)

BRIEF SUMMARY OF PRODUCT INFORMATION

The following is a brief summary only. Before prescribing, see complete prescribing information in ZANTAC® product labeling.

INDICATIONS AND USAGE: ZANTAC® is indicated in:

1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy.

Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSAGE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

Although recommended doses of ZANTAC do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Lack of experience to date precludes recommending ZANTAC for use in children or pregnant patients. Since ZANTAC is secreted in human milk, caution should be exercised when administered to a nursing mother.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to ZANTAC® administration. Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

There have been rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome): The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg twice a day.

GERD: The current recommended adult oral dosage is 150 mg twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

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Glaxo

Glaxo Inc.
Research Triangle Park, NC 27709

FUTURE/Continued

ganizations seek to improve productivity and reduce escalating costs of health care. The corporate sector is increasingly interested in weight control, stress management, health education and other "wellness" activities for employees.

Because many chronic diseases have their origin early in life, wellness programs in schools can help ensure that good health habits start young and become a way of life. Michigan school districts are beginning to appreciate and expand their role in health education; the Michigan Department of Education's model for comprehensive school health education is being adopted widely. Hospitals, health maintenance organizations and other providers also are emphasizing wellness and health education programs.

Modifying health-related behavior is very complex; more effort and resources must be focused on health education research and on bringing the benefits of health promotion to children, the elderly and the poor. Both public and private insurance coverage should be extended to cover a well-defined package of basic preventive services. Premium rates should reward efforts to stay well. Unfortunately, the current health care reimbursement system does little to encourage—and indeed may discourage—individuals from assuming more responsibility for their own health.

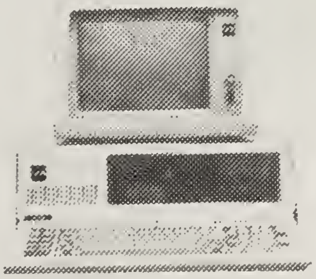
The health care delivery system

During the 1950s and 1960s, government fostered the growth of medical care services in many ways. Hill-Burton construction dollars force-fed explosive increases in the number of hospitals and beds. Medicaid and Medicare compensated providers for care they had previously given at no charge to the indigent and elderly and increased access by rich and poor alike to high quality medical care. After spending billions of dollars on building hospitals, enlarging medical schools and expanding access to medical care, government concluded in the 1970s that providers were delivering too much service. Through certificate of need programs and Medicare and Medicaid policies, government began to regulate against the development of health care services it had, in fact, stimulated and funded.

Corporate America was not far

Continued on page 400

MEDICAL AUTOMATION



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FUTURE/Continued

behind government. The labor contracts of the 1960s and 1970s gave workers access to a wide array of health care services at little or no cost to employees. Then, in the 1980s, just as government tightened the purse strings, corporate America decided the medical care industry was getting too rich at its expense.

The decision by government and business to limit spending on health care has left the health care system with an excess of beds, services and personnel. The result is more competition for existing health care dollars. The combination of spending limits and increased competition has introduced traditional business principles into the operation of health care facilities, producing a marketplace that rewards efficiency.

In the 1990s, competition will lead to a shrinking and consolidation of the nation's health care delivery system. There will be fewer beds and hospitals, particularly community hospitals; fewer medical and dental schools and students; fewer interns and residents; and fewer large medical centers. There will be more chains of health provider corporations (profit and nonprofit); more care extenders, such as physicians' assistants, nurses, home health and hospital care services; and more outpatient services. It is quite possible that by the year 2000 Michigan will have five or fewer corporate medical systems, each with a flagship hos-

Continued on page 402

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Critical judgment

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FUTURE/Continued

pital fed by regional hospitals, which are fed in turn by smaller satellite facilities. Each system will own and operate long-term care, hospice, home health and all other similar services. The problem is that the pendulum may shift too far toward construction; there result then would be a rationing of care brought about by the undersupply and higher prices of services.

Consumers' choices of hospitals, physicians and medical procedures will narrow. As options are reduced, consumers will have less access to personal medical care as they know it today. "Routine" health care and education will be handled largely by paraprofessionals, such as nurse practitioners, physicians' assistants and nutritionists.

Not only will free choice of providers be a privilege of wealth, but also the "dual system of care—one for the rich and one for the poor" will become more entrenched. Hospitals and nursing homes offering care exclusively to private payers may be established; these facilities may cater as well to foreign patients, proving that health care, like auto manufacturing, can be an international industry.

Michigan is spending more than one-half billion dollars per year on Medicaid, yet must defer to the federal government in determining who shall be eligible and what health care services they shall receive. State regulatory functions, such as licensing health care professionals and approving or disapproving facility plans for capital expenditures, have not been particularly effective in guaranteeing quality or constraining costs. The Michigan public mental health system is beset by clinical, quality of care and civil rights problems and has been relinquishing to the private sector a greater share of institutional care. State environmental health policies and regulations are set and administered by so many different departments and agencies that coherence is difficult to achieve. In additional, environmental health is rapidly becoming not so much a state as a national and, indeed, international issue.

It is far from clear that state government will enjoy any lasting role in making health care policy. By the year 2000, we envision state governments withdrawing from such activities as:

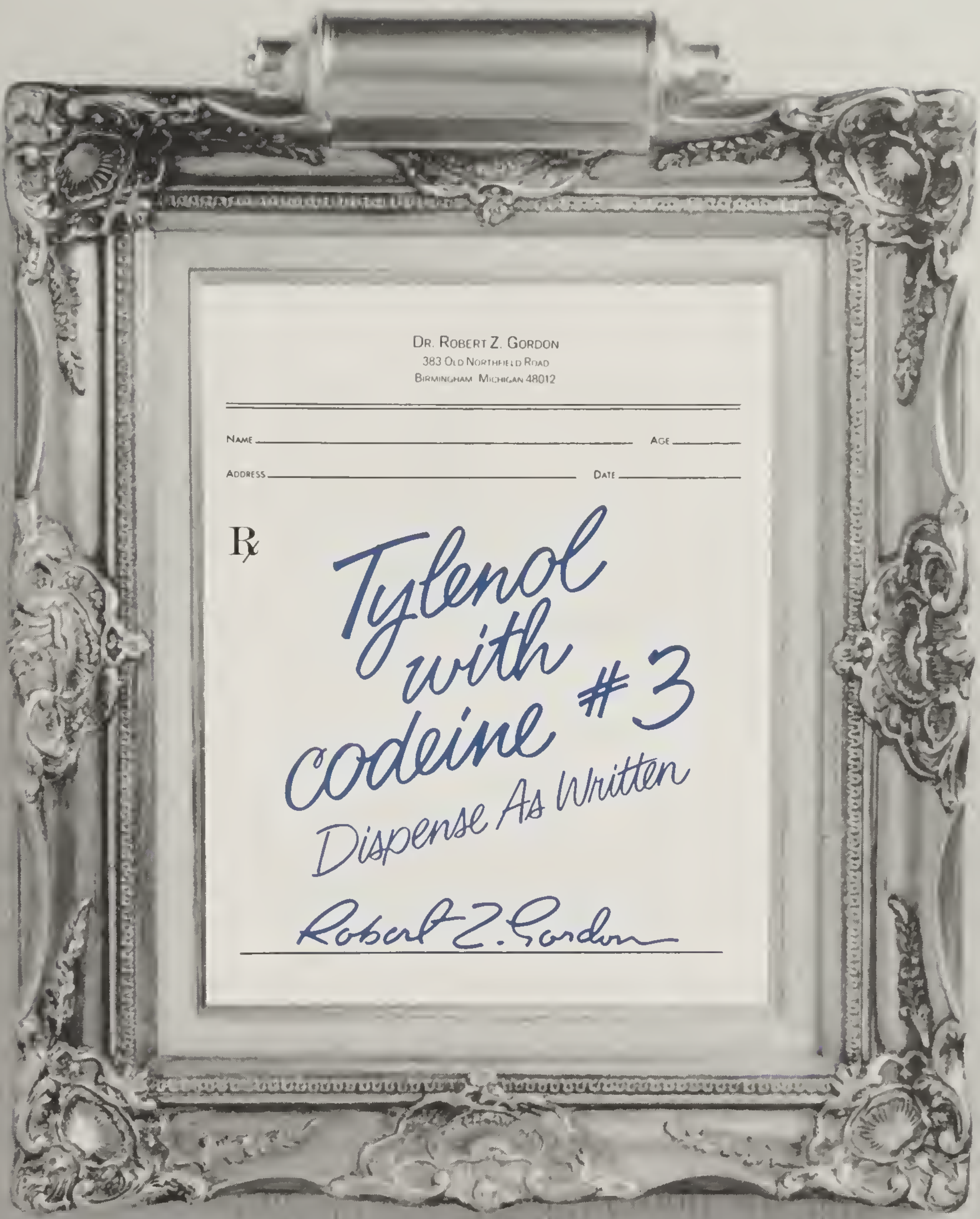
- financing health care for the indigent (Medicaid)
- arbitrating what health care services facilities will provide (certificate of need)
- operating health care institutions (the public mental health system)
- setting environmental standards

In *financing health care*, state government will increasingly be faced with the medical bills of the indigent and underinsured. In the past, to provide free or nearly free care to the poor, providers were able to overcharge the paying customers. As insurers and employers clamp down on medical care spending, hospitals, physicians and other providers will be increasingly unable to provide care to the indigent without reimbursement.

The challenge of assuring access to health care for the needy will be dropped on the doorstep of the US Capitol because no state can afford it. Certainly, within ten years there will be a national policy and reimbursement fund for medical care to the needy, or at the very least a national catastrophic fund to protect life savings of the aging from evaporating during a single illness. It is likely that Medicare and Medicaid will be merged into one program of reimbursement for those without financial means to pay for medical care; we foresee little likelihood that state and local governments can afford to participate in the combined program. Uncompensated care will be a major problem for hospitals until such a national strategy is implemented; uncompensated care in Michigan alone cost hospitals $214 million in 1984. As a trade-off for the federal government picking up Medicaid and uncompensated health care costs, the states may become more fully responsible for financing and operating other social welfare programs, such as income support and clothing, shelter and food allowances.

The *certificate of need* pro-

Continued on page 404



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FUTURE/Continued

gram, designed to limit capital expenditures to projects and services with demonstrated need, has been largely ineffective—not just in Michigan but throughout the nation. The program fails to restrain the vast majority of projects; it restricts competition—one consequence of which is artificial protection of inefficient health care institutions; it delays unnecessarily the introduction of labor-saving technologies; and it retards the integration of services into broad health care corporate systems. In this era, when public and private insurance reimbursement for costs is based on competitive prices, the best determinant of need for capital expenditure is the marketplace, not the government.

In the face of the inevitable consolidation of the health care system, state governments must plan to minimize the economic and social pain of dislocation and closure of care facilities. For example, Michigan must examine alternative uses for excess capacity in hospitals, one being long-term care facilities for the increasing older population.

The number of people institutionalized in Michigan's *public mental health system* has dropped dramatically. At the end of fiscal year 1959-60, more than 30,000 individuals were being cared for in Michigan public psychiatric hospitals and centers for the developmentally disabled. Today, the number is about 5,500. The Michigan Department of Mental Health now contracts with private hospitals and care-givers for much of the direct care that its patients historically received from the state. As the private sector is encouraged to expand psychiatric care for children, adolescents and adults, it is possible that within a decade Michigan will close the doors of all or nearly all its mental health institutions.

As the health care industry consolidates, public policy must center on improving access to and financing medical care. . .

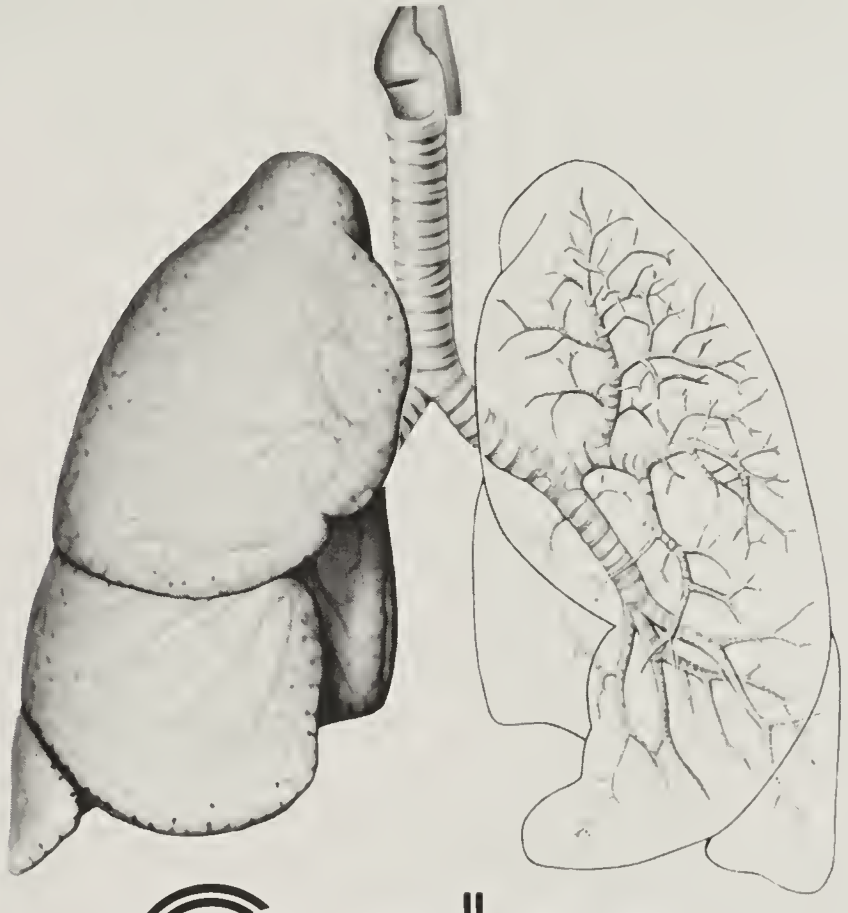
As the world shrinks and *environmental issues* take on global significance, standards for air and water quality, worker health and similar environmental health factors will be set by national and international bodies. States will defer more to the federal government for review and establishment of environmental standards, which in turn will seek the assistance of international bodies in assuring global uniformity on at least minimum standards. State governments trying to attract business will no longer need to lower environmental and health standards to be competitive.

While the role of state governments is decreasing in the areas noted above, they will increase in protecting and promoting individual health. We envision Michigan more actively:

- promoting health, rather than regulating health care systems;
- policing, rather than setting, environmental and health standards; and
- overseeing outcomes of medical care, rather than merely licensing health occupations, professions and institutions.

As the health care industry consolidates, public policy must center on improving access to and financing medical care for the elderly and the poor; the state's role will be subsumed by the federal government in this regard because of the expense. There are areas, however, in which the state can effectively serve its citizens. By reemphasizing traditional public health activities—promoting behavior changes, providing consumer and health education and disseminating information about communicable diseases—state government can have a beneficial effect on the public's health. The most good can be accomplished, however, by overseeing professional competency and the results of medical care, rather than by merely issuing credentials to health providers and facilities. ☐

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d.
offers effectiveness against the major causes of bacterial bronchitis

Haemophilus influenzae, Streptococcus pneumoniae
(ampicillin-susceptible and ampicillin-resistant)

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

Ceclor® (cefaclor)

Summary. Consult the package literature for prescribing information.

Indications: Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae, Haemophilus influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).

Contraindication:
Known allergy to cephalosporins.

Warnings:
CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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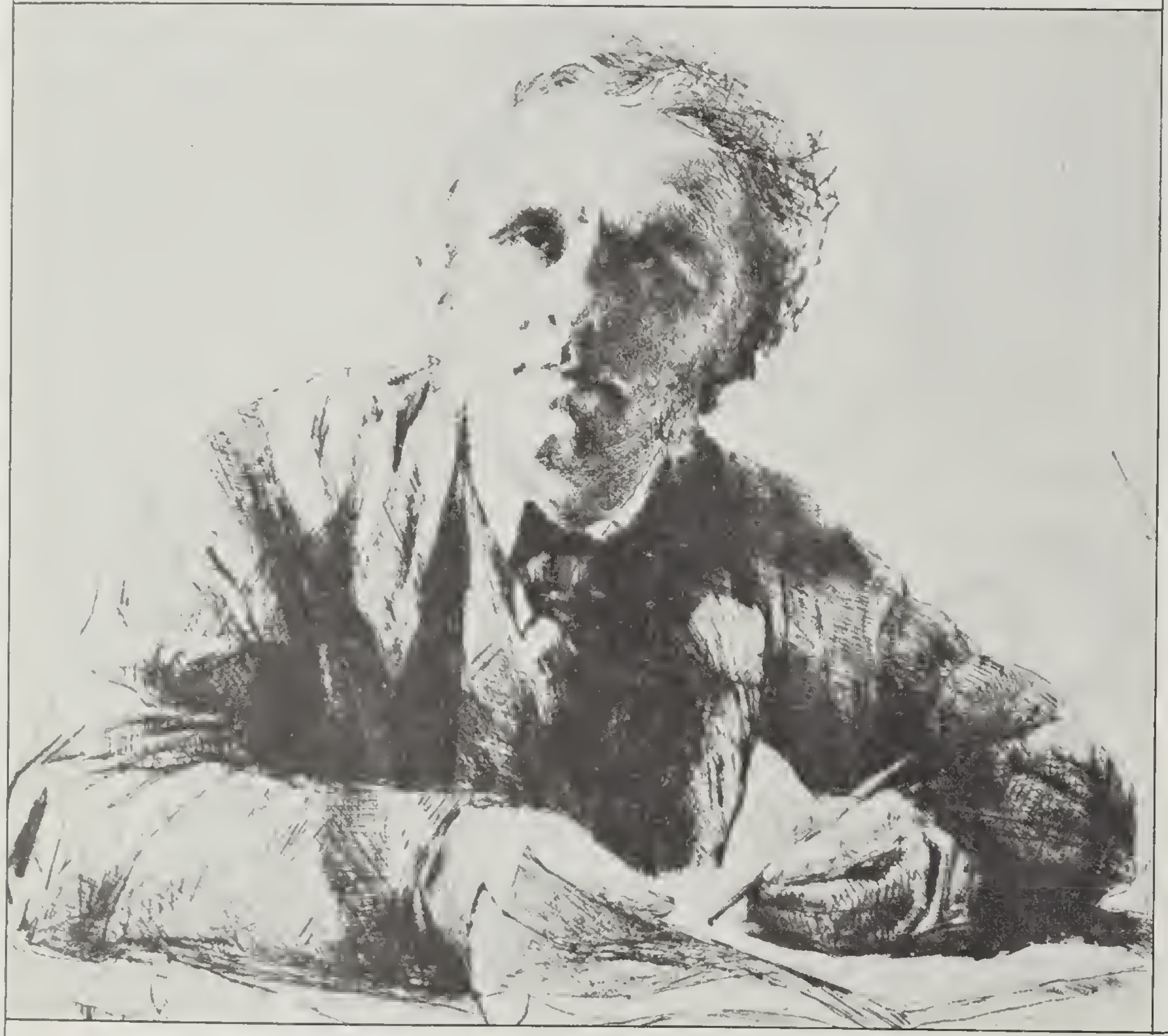
700241

The physician as artist: a call for entries



Sir Francis Seymour Haden (self-portrait). Original etching, self-portrait by Sir Francis Seymour Haden (English, 1818-1910), made at London in 1862. Haden, a distinguished surgeon of the Victorian era, achieved international renown as an etcher and landscape artist. He was founder and president of the Royal Society of Painter-Etchers and Engravers. In a lecture he summed up eloquently the benefits of art training for the medical profession: "How much sooner would the eye — accustomed to observe and estimate closely the differences of color, aspect, weight, and symmetry — learn to gauge their aberrations as the signs which make up the *facies* of the disease; how much better the hand, trained to portray them accurately, be able to direct with precision and safety the course of the knife!"

The marvelous human machine is capable of creating moments, vision, thoughts that transcend its physical properties. Humans' abilities for creating, for enjoying beauty and for inspiring it are the essence of the life physicians strive to further and to protect.

Many physicians themselves exhibit excellence in the arts as well as in the sciences. It is this bent toward the arts that *Michigan Medicine* seeks to explore through a new regular feature.

Are you a poet? A writer of prose? A composer or performer of music? A dancer? A sculptor, painter or weaver? A photographer?

The human body is an instrument for the production of art in the life of the human soul.

***Adventures of Ideas,* Chapter 18, Alfred North Whitehead.**

If so, we invite you to contribute your best works for publication in *Michigan Medicine*. If your creativity is expressed in media which need to be heard or otherwise personally experienced please describe them or send us photographs of your activities.

Michigan Medicine will publish the best of the contributions, beginning in September, in a new section of the magazine.

Please send your contribution to *Michigan Medicine*, PO Box 950, East Lansing, MI 48826-0950. *Michigan Medicine* does not guarantee return of works, but will strive where possible to return them in their original form.

"Living in the city
is lonely enough...
with herpes it's like
solitary confinement."

ZOVIRAX®
(acyclovir)
CAPSULES

Prevent genital herpes recurrences month after month with daily therapy.

(In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.)

Please see last page of this advertisement for brief summary of prescribing information.

ZOVIRAX®
(acyclovir)
CAPSULES

Help free your patients from recurrences.

Daily therapy

Coping with genital herpes is rarely easy. For some, the worst part is the pain and discomfort of frequent attacks — month after month, year after year. For others, the emotional burden presents a more difficult problem, leading to social isolation, anxiety, and diminished self-esteem.

Prevent or reduce recurrences

Although your patients have to live with herpes, they shouldn't have to suffer. Daily therapy with ZOVIRAX CAPSULES can help free them from the cycle of recurrent genital herpes. For many, one capsule three times a day can suppress recurrences completely while on therapy.

Generally well tolerated

Daily therapy with ZOVIRA CAPSULES is generally well tolerated. The most frequent adverse reactions reported during clinical trials were headache, diarrhea, nausea/ vomiting, vertigo, and arthralgia.

The physical and emotiona difficulties posed by genital herpes are unique for each patient. The frequency and severity of recurrent episode as well as the emotional impact of the disease, should be considered when selecting daily therapy with ZOVIRA CAPSULES.

Please see brief summary of prescribing information on next pag

Prevent recurrences month after month*

ZOVIRAX®
(acyclovir)
CAPSULES

Brief Summary

INDICATIONS AND USAGE: Zovirax Capsules are indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes in certain patients.

The severity of disease is variable depending upon the immune status of the patient, the frequency and duration of episodes, and the degree of cutaneous or systemic involvement. These factors should determine patient management, which may include symptomatic support and counseling only, or the institution of specific therapy. The physical, emotional and psychosocial difficulties posed by herpes infections as well as the degree of debilitation, particularly in immunocompromised patients, are unique for each patient, and the physician should determine therapeutic alternatives based on his or her understanding of the individual patient's needs. Thus Zovirax Capsules are not appropriate in treating all genital herpes infections. The following guidelines may be useful in weighing the benefit/risk considerations in specific disease categories:

First Episodes (primary and nonprimary infections — commonly known as initial genital herpes):

Double-blind, placebo-controlled studies have demonstrated that orally administered Zovirax significantly reduced the duration of acute infection (detection of virus in lesions by tissue culture) and lesion healing. The duration of pain and new lesion formation was decreased in some patient groups. The promptness of initiation of therapy and/or the patient's prior exposure to Herpes simplex virus may influence the degree of benefit from therapy. Patients with mild disease may derive less benefit than those with more severe episodes. In patients with extremely severe episodes, in which prostration, central nervous system involvement, urinary retention or inability to take oral medication require hospitalization and more aggressive management, therapy may be best initiated with intravenous Zovirax.

Recurrent Episodes:

Double-blind, placebo-controlled studies in patients with frequent recurrences (6 or more episodes per year) have shown that Zovirax Capsules given for 4 to 6 months prevented or reduced the frequency and/or severity of recurrences in greater than 95% of patients. Clinical recurrences were prevented in 40 to 75% of patients. Some patients experienced increased severity of the first episode following cessation of therapy; the severity of subsequent episodes and the effect on the natural history of the disease are still under study.

The safety and efficacy of orally administered acyclovir in the suppression of frequent episodes of genital herpes have been established only for up to 6 months. Chronic suppressive therapy is most appropriate when, in the judgement of the physician, the benefits of such a regimen outweigh known or potential adverse effects. In general, Zovirax Capsules should not be used for the suppression of recurrent disease in mildly affected patients. Unanswered questions concerning the human relevance of *in vitro* mutagenicity studies and reproductive toxicity studies in animals given very high doses of acyclovir for short periods (see Carcinogenesis, Mutagenesis, Impairment of Fertility) should be borne in mind when designing long-term management for individual patients. Discussion of these issues with patients will provide them the opportunity to weigh the potential for toxicity against the severity of their disease. Thus, this regimen should be considered only for appropriate patients and only for six months until the results of ongoing studies allow a more precise evaluation of the benefit/risk assessment of prolonged therapy.

Limited studies have shown that there are certain patients for whom intermittent short-term treatment of recurrent episodes is effective. This approach may be more appropriate than a suppressive regimen in patients with infrequent recurrences.

Immunocompromised patients with recurrent herpes infections can be treated with either intermittent or chronic suppressive therapy. Clinically significant resistance, although rare, is more likely to be seen with prolonged or repeated therapy in severely immunocompromised patients with active lesions.

CONTRAINDICATIONS: Zovirax Capsules are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulation.

WARNINGS: Zovirax Capsules are intended for oral ingestion only.

PRECAUTIONS: General: Zovirax has caused decreased spermatogenesis at high doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage and length of treatment should not be exceeded (see DOSAGE AND ADMINISTRATION).

Exposure of Herpes simplex isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of Herpes simplex virus to acyclovir and clinical response to therapy has yet to be established.

Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy.

Drug Interactions: Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of 50, 150 and 450 mg/kg given by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. In 2 *in vitro* cell transformation assays, used to provide preliminary assessment of potential oncogenicity in advance of these more definitive life-time bioassays in rodents, conflicting results were obtained. Acyclovir was positive at the highest dose used in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative in another transformation system considered less sensitive.

In acute studies, there was an increase, not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of 100 mg/kg acyclovir in rats but not Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters. In addition, no activity was found after 5 days dosing in a dominant lethal study in mice. In 6 of 11 microbial and mammalian cell assays, no evidence of mutagenicity was observed. At 3 loci in a Chinese hamster ovary cell line, the results were inconclusive. In 2 mammalian cell assays (human lymphocytes and L5178Y mouse lymphoma cells *in vitro*), positive responses for mutagenicity and chromosomal damage occurred, but only at concentrations at least 400 times the acyclovir plasma levels achieved in man.

Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). At 50 mg/kg/day s.c. in the rat, there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day. No effect upon implantation efficiency was observed when the same dose was administered intravenously. In a rat peri- and postnatal study at 50 mg/kg/day s.c., there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size. However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits, there were no drug-related reproductive effects.

Intraperitoneal doses of 320 or 80 mg/kg/day acyclovir given to rats for 1 and 6 months, respectively, caused testicular atrophy. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. Testicles were normal in dogs given 50 mg/kg/day, i.v. for one month.

Pregnancy: ***Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rat (50 mg/kg/day, s.c.) or rabbit (50 mg/kg/day, s.c. and i.v.). There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Zovirax is administered to a nursing woman. In nursing mothers, consideration should be given to not using acyclovir treatment or discontinuing breastfeeding.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS — Short-Term Administration: The most frequent adverse reactions reported during clinical trials were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat.

Long-Term Administration: The most frequent adverse reactions reported in studies of daily therapy for 3 to 6 months were headache in 33 of 251 patients (13.1%), diarrhea in 22 of 251 (8.8%), nausea and/or vomiting in 20 of 251 (8.0%), vertigo in 9 of 251 (3.6%), and arthralgia in 9 of 251 (3.6%). Less frequent adverse reactions, each of which occurred in less than 3% of the 251 patients (see number of patients in parentheses), included skin rash (7), insomnia (4), fatigue (7), fever (4), palpitations (1), sore throat (2), superficial thrombophlebitis (1), muscle cramps (2), pars planitis (1), menstrual abnormality (4), acne (3), lymphadenopathy (2), irritability (1), accelerated hair loss (1), and depression (1).

DOSAGE AND ADMINISTRATION: Treatment of initial genital herpes: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 10 days (total 50 capsules).

Chronic suppressive therapy for recurrent disease: One 200 mg capsule 3 times daily for up to 6 months. Some patients may require more drug, up to one 200 mg capsule 5 times daily for up to 6 months.

Intermittent Therapy: One 200 mg capsule every 4 hours, while awake, for a total of 5 capsules daily for 5 days (total 25 capsules). Therapy should be initiated at the earliest sign or symptom (prodrome) of recurrence.

Patients With Acute or Chronic Renal Impairment: One 200 mg capsule every 12 hours is recommended for patients with creatinine clearance ≤10 ml/min/1.73/m².

HOW SUPPLIED: Zovirax Capsules (blue, opaque) containing 200 mg acyclovir and printed with "Wellcome ZOVIRAX 200"- Bottles of 100 (NDC-0081-0991-55) and unit dose pack of 100 (NDC-0081-0991-56).

Store at 15°-30°C (59°-86°F) and protect from light.

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*In controlled studies, recurrences were totally prevented for 4 to 6 months in up to 75% of patients.

Wellcome
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Research Triangle Park
North Carolina 27709

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ACP cautions about parenteral nutrition

Total parenteral nutrition (TPN) should be used only for certain groups of patients, according to a statement from the American College of Physicians (ACP).

In 1985, approximately 550,000 hospitalized patients received parenteral nutritional support at an estimated cost for solution and equipment of $1 billion. A recent review of the Medicare prospective payment system suggested it costs more to treat patients requiring nutritional support.

The statement—developed by ACP's Clinical Efficacy Assessment Project (CEAP)—is based on an analysis of 18 clinical trials. Most of the studies could not detect reductions in major complications or death due to use of TPN—also called hyperalimentation, parenteral nutritional support, or parenteral feeding.

However, notes the statement, there were some design flaws in the available studies, and on the basis of clinical judgement alone, ACP recommends perioperative parenteral nutritional support for severely malnourished patients having major surgery (e.g., intra-abdominal, noncardiac intrathoracic surgery).

Postoperative TPN is recommended for selected groups of moderately malnourished and previously well nourished patients who have surgery usually resulting in prolonged periods—10 days or more— with inadequate nutritional intake (e.g., pancreaticoduodenectomy or esophagogastrectomy involving total gastric resection). Some of these patients may be fed via a jejunostomy (small-intestine feeding) tube as an alternative to TPN.

Postoperative parenteral nutrition is also recommended for previously well nourished patients who develop postoperative complications expected to result in prolonged periods—10 days or more—with inadequate intake (e.g., small bowel resection associated with peritonitis).

ACP recommends physicians be selective in their use of TPN. Although parenteral nutritional support is a feasible and reasonably safe method of improving patients' nutritional status, approximately 6.7 percent of patients treated with TPN will experience such iatrogenic complications as pneumothorax, subclavian and axillary vein thrombosis and septicemia.

WSU to gain research building

A new Wayne State University medical research facility, which was only a "wish list" item little more than a year ago, now has a construction completion date of late 1988. The Louis M. Elliman Clinical Research Building will be built on the northeast corner of Canfield and Brush.

"With the addition of the Elliman research building, the School of Medicine and the Detroit Medical Center will have available to faculty and staff the finest modern facilities to conduct research of the highest caliber," said Henry L. Nadler, MD, dean of medicine.

Besides the addition of much-needed space, the building will provide the consolidation of several departments; the facilitation of interdisciplinary interaction; and the addition of expanded, modern facilities that will enhance the school's ability to attract top scientists and to obtain additional funding.

In total, the building will provide 63,000 square feet of space for 48 new laboratories. The modular-designed structure will have four floors and a basement.

The building is named for Louis M. Elliman, who with his wife donated $2 million to the School of Medicine last year.

Stroke prevention

Sixteen medical centers, including Henry Ford Hospital, have been chosen to participate in a major national study to determine whether a popular operation is more effective than a daily dose of aspirin in preventing strokes.

The five-year study will be supported by an $11.6 million grant from the National Institute of Neurological and Communicative Disorders and Stroke.

Calvin Ernst, MD, head of Vascular Surgery, is in charge of Henry Ford Hospital's part of the Asymptomatic Carotid Atherosclerosis Study (ACAS). K.M.A. Welch, MD, chairman of neurology, will head the team of neurologists.

ACAS will involve 1,500 patients nationwide who have a significant narrowing (due to atherosclerotic plaque) of the carotid artery that supplies blood to the brain, but who exhibit no stroke symptoms.

The operation, endarterectomy, is performed more than 125,000 times a year, making it one of the most common surgeries in the US. About half are done on patients who show no stroke symptoms. But many physicians have questioned whether the surgery, which carries some risks, is better than medical treatment and have called for a multi-center study.

In the study, half the 1,500 patients will get an endarterectomy, and half will not. They will be chosen at random.

One hundred patients aged 18 to 75 will be involved in Henry Ford Hospital's portion of the study. Candidates will be referred by community physicians, noninvasive labs, and angiography facilities. To be eligible, a patient must have a carotid artery narrowing confirmed by at least two specified tests. The patients will be randomly assigned to either the medical group or the surgical group. Following surgery, the surgical patients will be

Continued on next page

NEED PHYSICIANS?

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on the same drug therapy and risk-reduction counseling as the medical group.

According to Doctor Ernst, the study will seek the answers to two questions:

- Will the surgical procedure reduce the numbers of strokes and "mini" strokes significantly more than aspirin alone?
- If it does, is the reduction in the numbers sufficiently greater than the rate of complications resulting from the surgery to justify the procedure?

In addition, ACAS will look at the relative effectiveness of several different tests for detecting the narrowing of the carotid. It will also evaluate the CT scan for finding brain damage after a stroke and to spot possible unreported strokes.

Participants in the study include many university medical centers. Henry Ford Hospital is the only Michigan center invited to participate.

Center a year old

The Transplant Policy Center, the first of its kind in the nation, recently celebrated its first anniversay with the program, "Looking ahead for Michigan and the nation."

Jeremiah G. Turcotte, MD, director of the center and director of the University of Michigan Organ Transplantation Center, hosted and moderated the program, which featured a panel of organ transplant patients and organ donor families. The event took place in the Towsley Center, U-M Medical Center.

The Transplant Policy Center is a statewide agency established in 1986 through the joint efforts of state government, Michigan Department of Public Health and the University of Michigan. Its purpose is to study the economic, ethical, social, educational and public policy issues related to organ transplantation in Michigan.

Gloria R. Smith, PhD, director of the Michigan Department of Public Health, read greetings from the governor and talked about the state's perspective on issues of organ transplantation. George D. Zuidema, MD, U-M vice-provost for medical affairs, presented the university's viewpoint.

Chairpersons of four of the six advisory committees briefly outlined research and investigations on public policy issues planned for the coming year.

Seventy individuals with expertise and interest in organ transplantation serve on the

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enter's advisory committees, vhich meets monthly. They adise on areas of research and inestigation.

Diabetes and retina studied

This year more than 5,000 peole in the prime of life—between he ages of 20 and 60—will comletely lose their sight and many nore will suffer from lesser legrees of retina damage, one of he principal complications of diabetes.

Henry Ford Hospital's ophthalmology department is one of 25 North American sites looking for volunteers to participate in a study which will evaluate the effectiveness of a new drug in preventing or slowing damage to the retina. All funding for the study will be provided by the manufacturers of the study drug.

Currently no approved drug has been proven effective in the prevention or decreased progression of proliferative retinopathy. It is estimated that more than 90 percent of long-term diabetics will develop it.

The drug—an aldose reductase inhibitor—works to prevent the aldose reductase enzyme from turning the diabetic's elevated level of glucose into sugar alcohol, which is believed to be the cause of diabetic-related blindness.

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University of Michigan Medical Center

Board of Medicine looks at the benzodiazepine issue

By Thomas H. DeKornfeld, MD

The benzodiazepines are among the most widely prescribed drugs in the world. In fact, it can almost be said that a very significant percentage of the population seems to suffer from a chronic valium deficiency as judged by the number of prescriptions which are written for this drug.

While, as a group, the benzodiazepines are among the safer central nervous system active drugs, they are certainly not without danger. Immoderate and improper use can and does lead to serious emotional and physical problems.

A study

A thoughtful and concerned legislator asked the Board to study this problem and to regulate the prescription of benzodiazepines by promulgating rules just as the Board did for amphetamines some years ago.

The Board gave this matter very serious consideration. Rules were drafted and distributed widely as part of the promulgation process. A public hearing was held and comments were solicited from a wide range of interested parties. Sources included physicians, professional organizations, pharmaceutical manufacturers and others. The opinions submitted to the Board varied from the cautiously supportive to the hysterically opposed. Few, if any, claimed that the benzodiazepines were harmless, but most seemed to feel that regulation at this time was not necessary.

The Board, by unanimous vote, decided not to promulgate benzodiazepine rules, but to keep a watchful eye on prescription practices.

The opponents argued that regulation of any kind would hamper the right of physicians to do as they pleased, that benzodiazepines were not dangerous enough to warrant any regulatory activity, and that regulation would significantly increase the cost of health care. One physician suggested that instead of regulating benzodiazepines, the Board should outlaw abortions. Much of the opposition came from psychiatrists and from the manufacturers of the benzodiazepines.

A watchful eye

After studying the pros and cons, the Board by unanimous vote decided not to promulgate benzodiazepine rules at this time but to keep a watchful eye on benzodiazepine prescription practices. The Board also requested the Bureau of Health Services to advise all licensed physicians in the state of its serious interest in this matter. As a result of this request, the Bureau has mailed out an "alert" on this subject, which you should have received by this time.

This column in *Michigan Medicine* is also the result of the Board's desire to convey to all practitioners an earnest request. Let all physicians review their prescription practices relative to benzodiazepines. The Board feels very strongly that benzodiazepines, just as all other controlled substances, can be abused and therefore require great caution in prescribing.

As with any other drug, good medical practice requires that benzodiazepines be prescribed only when clearly indicated, that they should not be prescribed for the ordinary stresses and strains of daily living, that both the duration and the intensity of the therapy be held to an irreducible minimum, that the effects of therapy be carefully assessed, and that therapy be discontinued as soon as possible. It is also highly important that every physician prescribing benzodiazepines be thoroughly familiar with the clinical pharmacology of this large group of related agents so that the appropriate benzodiazepine be used for the appropriate indication.

The Board decided not to promulgate rules on benzodiazepines

Continued on page 416

Doctor DeKornfeld is administrator, Michigan Board of Medicine.

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BENZODIAZEPINES/Continued

at this time. This should not be interpreted to mean that the Board is happy with the way that some physicians prescribe benzodiazepines. The Board sincerely hopes that all physicians will heed the concern expressed in the "alert" and in this column. The Board will continue to watch the benzodiazepine scene with interest and concern. If the utilization of these agents continues to increase, the Board may well reconsider its present stance and promulgate rules significantly curtailing the physicians' freedom in prescribing these useful, but by no means harmless, pharmaceutic agents. As the learned Roman has said, "Sapienti sat," which translates freely as, "Nuff said!"☐

Board of Medicine actions

The following actions of th Michigan Board of Medicin were taken following investigativ and appropriate action and ar reproduced verbatim from sum maries prepared by the Michiga Department of Licensing an Regulation.

Name: Richard Sundling, MI

Action, Date Taken: Licens Revoked, May 1, 1987

Reason: Drug Diversion/Per sonal Use

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ɔre prescribing, see complete prescribing information in SK&F CO.
ature or *PDR*. The following is a brief summary.

'ARNING

ıis drug is not indicated for initial therapy of edema or hyperten-
on. Edema or hypertension requires therapy titrated to the individual.
this combination represents the dosage so determined, its use
ay be more convenient in patient management. Treatment of hyper-
nsion and edema is not static, but must be reevaluated as con-
tions in each patient warrant.

traindications: Concomitant use with other potassium-sparing agents
ı as spironolactone or amiloride Further use in anuria, progressive
l or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum
ssium Hypersensitivity to either component or other sulfonamide-
ved drugs.

nings: **Do not use potassium supplements, dietary or otherwise,**
ss hypokalemia develops or dietary intake of potassium is markedly
aired. If supplementary potassium is needed, potassium tablets
uld not be used. Hyperkalemia can occur, and has been associated
cardiac irregularities. It is more likely in the severely ill, with urine
me less than one liter/day, the elderly and diabetics with suspected
onfirmed renal insufficiency Periodically, serum K$^+$ levels should be
rmined. If hyperkalemia develops, substitute a thiazide alone, restrict
intake. **Associated widened QRS complex or arrhythmia requires**
npt additional therapy. Thiazides cross the placental barrier and
ear in cord blood. Use in pregnancy requires weighing anticipated
efits against possible hazards, including fetal or neonatal jaundice,
mbocytopenia, other adverse reactions seen in adults. Thiazides
ear and triamterene may appear in breast milk. If their use is essential,
patient should stop nursing. Adequate information on use in children
t available. Sensitivity reactions may occur in patients with or with-
a history of allergy or bronchial asthma. Possible exacerbation or
ation of systemic lupus erythematosus has been reported with
zide diuretics.

cautions: The bioavailability of the hydrochlorothiazide component of
azide' is about 50% of the bioavailability of the single entity
oretically, a patient transferred from the single entities of triamterene
hydrochlorothiazide may show an increase in blood pressure or fluid
ntion. Similarly, it is also possible that the lesser hydrochlorothiazide
vailability could lead to increased serum potassium levels. However,
nsive clinical experience with 'Dyazide' suggests that these conditions
e not been commonly observed in clinical practice. Angiotensin-
verting enzyme (ACE) inhibitors can elevate serum potassium; use
caution with 'Dyazide'. Do periodic serum electrolyte determinations
ticularly important in patients vomiting excessively or receiving
nteral fluids, and during concurrent use with amphotericin B or
icosteroids or corticotropin [ACTH]). Periodic BUN and serum
atinine determinations should be made, especially in the elderly,
etics or those with suspected or confirmed renal insufficiency
nulative effects of the drug may develop in patients with impaired renal
ction. Thiazides should be used with caution in patients with impaired
atic function. They can precipitate coma in patients with severe liver
ease. Observe regularly for possible blood dyscrasias, liver damage,
er idiosyncratic reactions. Blood dyscrasias have been reported in
ents receiving triamterene, and leukopenia, thrombocytopenia,
anulocytosis, and aplastic and hemolytic anemia have been reported
thiazides. Thiazides may cause manifestation of latent diabetes
litus. The effects of oral anticoagulants may be decreased when
d concurrently with hydrochlorothiazide; dosage adjustments may be
essary Clinically insignificant reductions in arterial responsiveness
orepinephrine have been reported. Thiazides have also been shown to
ease the paralyzing effect of nondepolarizing muscle relaxants such
ubocurarine. Triamterene is a weak folic acid antagonist. Do periodic
od studies in cirrhotics with splenomegaly. Antihypertensive effects
be enhanced in post-sympathectomy patients. Use cautiously in
gical patients. Triamterene has been found in renal stones in associa-
with the other usual calculus components Therefore, 'Dyazide'
uld be used with caution in patients with histories of stone formation.
ew occurrences of acute renal failure have been reported in patients
'Dyazide' when treated with indomethacin. Therefore, caution is
ised in administering nonsteroidal anti-inflammatory agents with
azide'. The following may occur: transient elevated BUN or creatinine
oth, hyperglycemia and glycosuria (diabetic insulin requirements may
ltered), hyperuricemia and gout, digitalis intoxication (in hypokalemia),
reasing alkali reserve with possible metabolic acidosis. 'Dyazide'
rferes with fluorescent measurement of quinidine. Hypokalemia is
ommon with 'Dyazide', but should it develop, corrective measures
uld be taken such as potassium supplementation or increased dietary
ke of potassium-rich foods. Corrective measures should be instituted
tiously and serum potassium levels determined. Discontinue correc-
measures and 'Dyazide' should laboratory values reveal elevated
um potassium. Chloride deficit may occur as well as dilutional
onatremia. Concurrent use with chlorpropamide may increase the risk
severe hyponatremia Serum PBI levels may decrease without signs
thyroid disturbance. Calcium excretion is decreased by thiazides.
azide' should be withdrawn before conducting tests for parathyroid
ction. Thiazides may add to or potentiate the action of other anti-
ertensive drugs. Diuretics reduce renal clearance of lithium and
ease the risk of lithium toxicity.

'erse Reactions: Muscle cramps, weakness, dizziness, headache,
mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other
matological conditions; nausea and vomiting, diarrhea, constipation,
er gastrointestinal disturbances; postural hypotension (may be
ravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis,
esthesias, icterus, pancreatitis, xanthopsia and respiratory distress
luding pneumonitis and pulmonary edema, transient blurred vision,
ladenitis, and vertigo have occurred with thiazides alone. Triamterene
been found in renal stones in association with other usual calculus
nponents. Rare incidents of acute interstitial nephritis have been
orted. Impotence has been reported in a few patients on 'Dyazide',
ıough a causal relationship has not been established.

plied: 'Dyazide' is supplied as a red and white capsule, in bottles of
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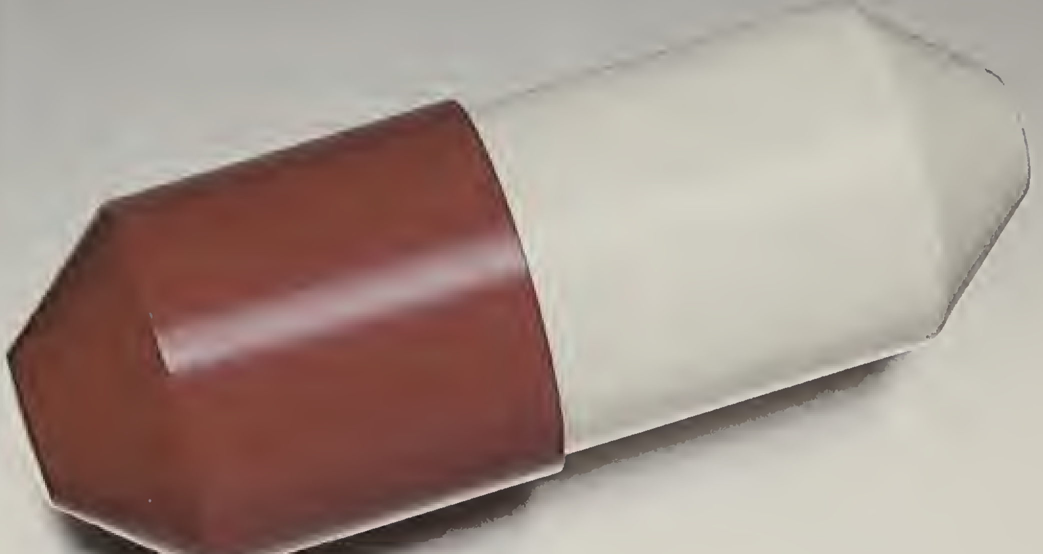

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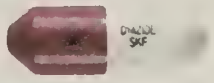

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MATERNAL HEALTH DESK REFERENCE CARD NO. 11-B

(Sponsored and prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society.)

DIABETES IN PREGNANCY

This combination represents a classic example of a normal physiologic event (pregnancy) occurring concomitantly with a chronic metabolic disease (diabetes). Preconceptual counseling is ideal to improve the outcome of pregnancy.

CLASSIFICATION (AMERICAN DIABETIC ASSOCIATION, 1983)

1. TYPE I: Insulin dependent diabetes mellitus.
2. TYPE II: Non-Insulin dependent diabetes mellitus.
3. GESTATIONAL DIABETES: The disease is diagnosed during pregnancy with two abnormal values on a 3-hour oral GTT (100 gm. glucose).
4. IMPAIRED GLUCOSE TOLERANCE: Final diagnosis is established when a positive GTT persists beyond the third post partum month.

RISK ASSESSMENT

All pregnant patients should be assessed chemically for diabetes during pregnancy. In the presence of risk factors more frequent interval testing is recommended.

SCREENING

a) 50 grams of oral glucose, at least 2 hours postprandial. Determination of 1 hour post load blood glucose (venous or capillary) > 135 ml/dl[1] or;

b) After patient has a "routine" meal a 2-hour postprandial blood glucose may be drawn.

RISK FACTORS

Pregnancy losses (spontaneous abortions or stillbirths)
Obesity
Family history of diabetes
Previous gestational diabetes mellitus
History of large babies
Positive symptoms of diabetes
Glycosuria

DIAGNOSIS

After adequate dietary preparation, a 3-hour oral GTT with 100 gm. glucose load unless previously diagnosed.[2]

FOLLOW UP

POSITIVE SCREEN — NEGATIVE GTT: Repeat screen by 28 weeks gestation. A *third* screen may be recommended on selected patients during the third trimester.

POSITIVE SCREEN — POSITIVE GTT: Individualized nutritional counseling. 35-40 Kcal/kg. = 1,800-2,350 K/cal.

Carbohydrates:	50-60% complex, unrefined
Protein:	12-20%
Saturated fatty acids:	10% remainder monounsaturated

- The meal distribution and number needs to be adjusted to the individual.
- Physical activity is encouraged.
- Individual consideration for *obese* women is necessary.
- Beware of first trimester food intolerance leading to hypoglycemia.
- Frequent prenatal visits are necessary.

For insulin dependent diabetics, individualized doses, methods of administration and variable schedules are necessary. Several different insulin preparations are available, and the physician utilizing them must be familiar with their type, source, purity and effectiveness. Often, there is a narrow margin between effectiveness and overdose.

A pregnant diabetic represents a condition that demands a team approach for management. It is recommended that the primary care physician utilize available consultative services.

OBSTETRICIAN:	Responsible for prenatal and obstetrical decisions.
NUTRITIONIST:	Monitors patient's nutrition, compliance with diet and weight.
PERINATAL NURSE: EDUCATOR:	Patient education — monitors patient's with home and life requirements.

Use of home glucose monitoring is encouraged. According to the stage of gestation (stabilization, long term control, periodic changes) the number of blood tests per day changes. The frequency of prenatal visits needs to be individualized.

In addition to the laboratory determinations usually carried out during standard prenatal care, the following studies might be indicated:

1. Appropriate prenatal diagnosis
2. Genetic counseling
3. Maternal serum alpha-fetoprotein (between 16-20 weeks)
4. Serial ultrasound
5. Ophthalmologic examination
6. Hb $A1_C > 8\%$.[3]

Poor control, emotional stress and infections are common problems and may precipitate diabetic ketoacidosis. This life threatening condition necessitates immediate expert management. Other complications (e.g. pregnancy induced hypertension and pyelonephritis) are common and their early detection is critical.

LOCATION AND TIMING OF DELIVERY

Early hospitalization (34 weeks) has historically been utilized for insulin dependent diabetics. In the compliant or well controlled diabetic, ambulatory management is safe, feasible, less expensive and less stressful for patient and family. The brittle or non-compliant diabetic may require liberal hospitalization.

Non-stress testing is initiated at 34 weeks gestation or earlier as indicated. Frequency of testing varies from every 3 to 7 days. Contraction stress testing (C.S.T.) may be utilized if the non-stress test becomes non-reactive or suspicious.

An overall evaluation of fetal and metabolic parameters is utilized to decide timing of delivery. Fetal lung maturity is detectable through amniotic fluid samples. Daily maternal evaluation of number of fetal movements and periodic biophysical profile add to the clinical follow-up.

Labor may be safely induced when cervical conditions are favorable under close uterine and fetal heart rate monitoring. Control of maternal glucose during labor is critical. A continuous low dose insulin infusion may be utilized (0.25 — 2 U/hr., regular insulin). A 5% dextrose solution is used at a rate of 1000 ml. per shift (125 ml/hr.). Blood glucose is determined hourly (finger stick at bedside).

A pediatrician should be present in the delivery room. Immediate post partum drop in insulin requirement is expected. Insulin coverage must be judiciously utilized. Determine blood glucose before meals as needed.

POST PARTUM CARE

Compliant patients will maintain their control. Others will benefit from a system of visiting nurses. Re-evaluate all gestational diabetics 6-12 weeks post partum with an oral 3-hour GTT following a p.o. load of 75 gm (capillary finger stick > 120 ml%).[4] Recommend continuation of medical supervision to those who do not return to normal.

FAMILY PLANNING

Will be individualized according to the patient's metabolic status, age, previous history and personal desires.

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This Reference Card was written for the Maternal and Perinatal Health Committee by Federico G. Mariona, MD, FACOG, FACS. April 1987

This Desk Reference Card describes methods and techniques of clinical practice that are currently acceptable and used by recognized authorities. However, it does not represent official policy or recommendations of the Michigan State Medical Society, and its publication should not be construed as excluding other acceptable methods of handling similar problems.

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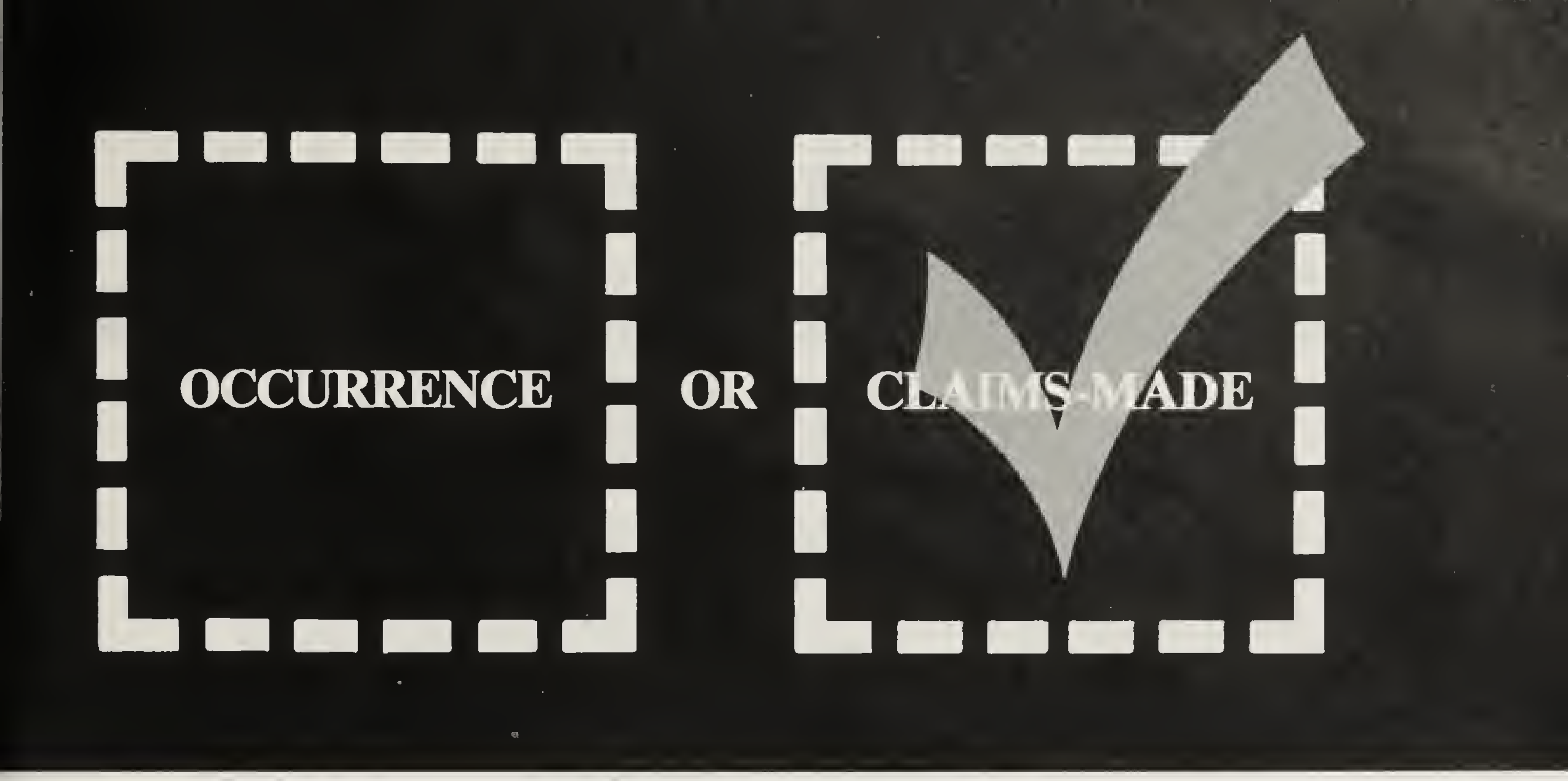
45610 Spring Lane
Utica 48087

Iqbal Jan, MD —FP/IM
22122 W. Nine Mile Rd.
Southfield 48034

Charles E. Jessup, DO —EM
6297 Dixie Hwy.
Bridgeport 48722

Joon K. Kim, MD —DR
3536 Sunnydale
Birmingham 48010

Michael E. Katz, MD —DR
Henry Ford Hosp. Dept./Rad.
Detroit 48202 ☐



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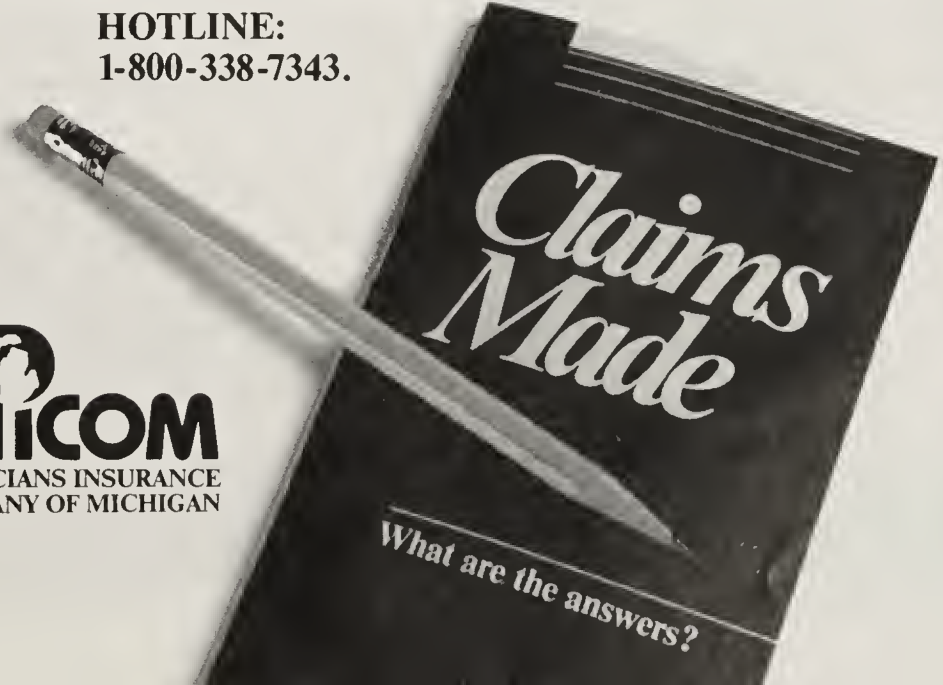

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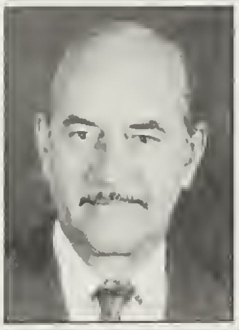
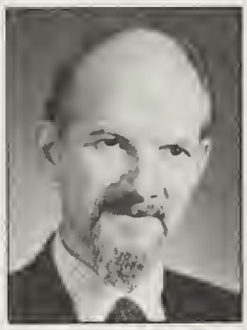
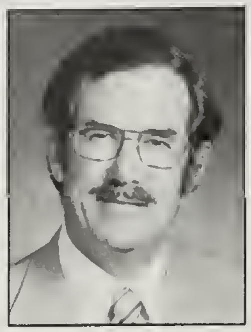

Caldwell

Gerard


Linnell


Payne

Harvey Sparks, MD and **James Trosko, MD**, both of East Lansing, are recipients of Michigan State University Distinguished Faculty Awards. ...**John Johnson, MD**, East Lansing, has been awarded a $99,198 grant from the National Science Foundation for the continuation of his work at MSU on the phylogenetic analysis of mammalian relationships through study of their brains. ...**Daniel Mazzuchi, MD**, East Lansing will be Assistant Dean for MSU's College of Human Medicine Upper Peninsula Medical Education Program effective July 1. ...**Jeremiah Turcotte, MD**, Ann Arbor, was awarded the 56th Mayo Lectureship at University of Michigan Medical Center. His lecture was titled, "Transplantation: Surgery's Success, Society's Quandary." ... **Walter Averill, III, MD**, was elected chairman of the Saginaw County Board of Mental Health. ...**Albert Dugan, MD**, Grand Rapids, was elected president of the Kent Medical Foundation, a charitable trust fund founded by the Kent County Medical Society. ...**T. Calvin Blair, MD**, is president-elect of the Ingham County Medical Society. ...**John Keyes, MD**, has retired from his cardiology practice after 50 years of service. ...**Ralph E. Bauer, MD**, Lathrup Village, retired after 30 years of practice in anesthesiology. ...**John R. Caldwell, MD**, Detroit, has been appointed chairperson for the Metropolitan Detroit Coalition for Blood Pressure Control. ...**Karen Thompson-Cardwell, MD**, Detroit, has been awarded a post-graduate fellowship by the College of Human Medicine at MSU. ...**Jacob L. Chason, MD**, Bloomfield Hills, received the "Distinguished Physician Award" at the 19th annual Michigan Neurological Association meeting. ...**Pedro Cortes, MD**, Detroit, was elected to the board of directors of the Michigan Affiliate of the American Diabetes Association. **Jose Goldman, MD, PhD**, Detroit, was elected as vice-president of the organization. ...**D'Anne Kleinsmith, MD**, Detroit, was recently elected secretary-treasurer of the Women's Dermatological Society. ...**Warren Lockette, MD**, Detroit, recently received a Clinician-Scientist Award from the American Heart Association for research on vascular reactivity in hypertension. ...**S. David Nathanson, MD**, Detroit, has been awarded a $227,877 grant from the National Institutes of Health/National Cancer Institute. The three year grant will support studies relating to the spread of malignant tumors. ...**Bruce Relya, MD**, Detroit, was honorary race director of the West Bloomfield Half Marathon. ...**Boy Frame, MD**, formerly of Grosse Pointe Park, was posthumously awarded a Mastership by the Board of Regents of the American College of Physicians. ...**Joel S. Dreyer, MD**, was awarded the Chesed VeRachamim Humanitarian Award by the Akiva Hebrew Day School in Lathrup Village. ...**Roy Gerard, MD**, East Lansing, has been named interim director of the Institute for International Health at MSU. ...The 1987 Outstanding Teaching Award from the Ambulatory Pediatrics Association was received by the Chronic Illness Teaching Program, a residency program at MSU administered by **Barbara Desguin, MD**. ...**Bruce Drukker, MD**, East Lansing, is the editor of a monograph on obstetrics and gynecology to be released by the Saunders Publishing Company this fall. ...**Beverly C. Payne, MD**, Ann Arbor, was awarded a Mastership by the American College of Physicians. ...**Robert A. Gross, MD, PhD**, Ann Arbor, received the S. Weir Mitchell

Continued on page 426

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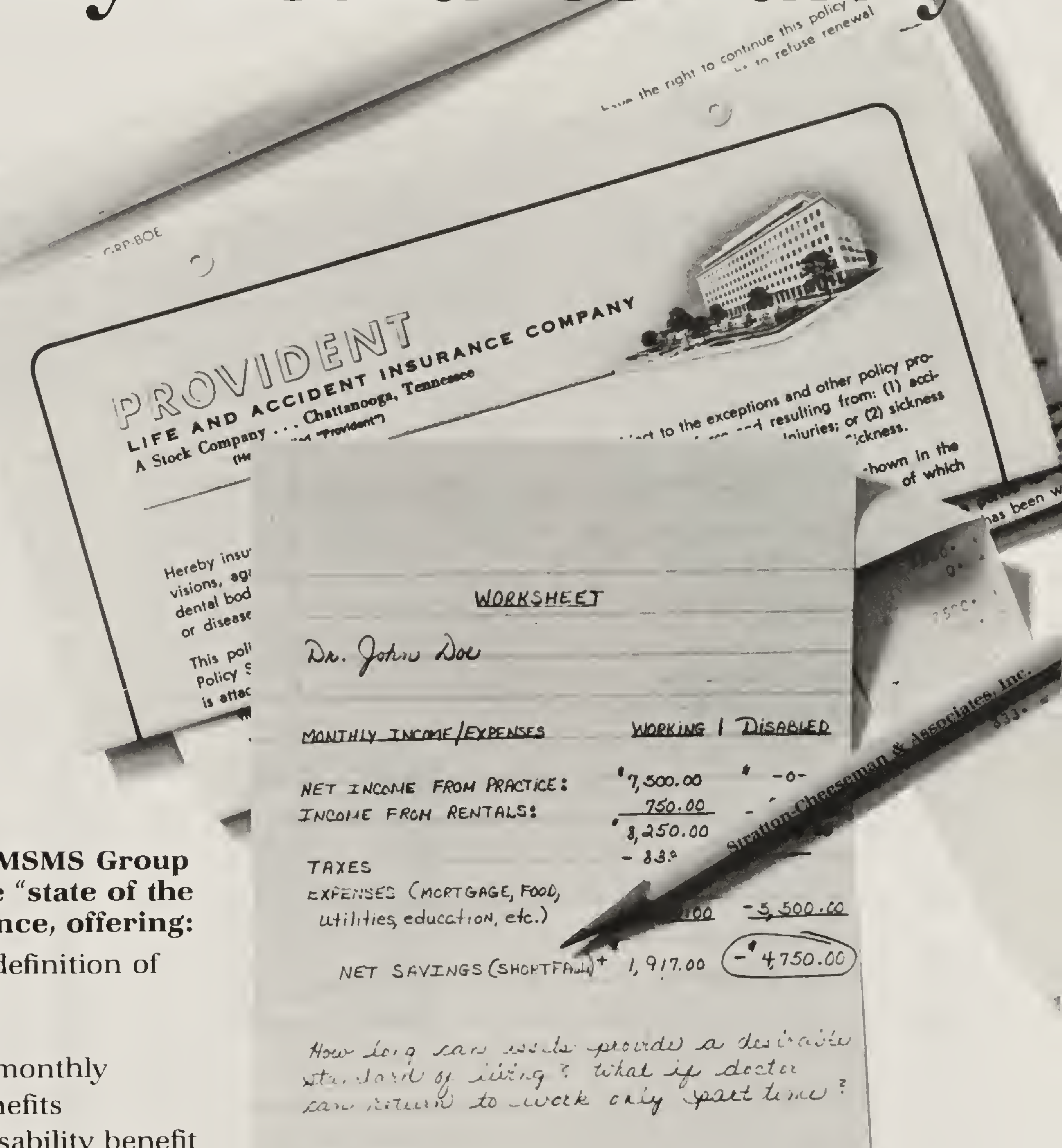
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Award for research from the American Academy of Neurology. ...**Harold E. Bowman, MD**, Lansing, has been appointed to the executive committee of the American Joint Committee on Cancer (AJCC) as a representative of the College of American Pathologists. ...**Donald H. Kuiper, MD**, Lansing, has been re-elected as treasurer of the Federation of State Medical Boards of the United States. ...**Wilford E. Maldonado, MD**, Lansing, was awarded fellowship in the American College of Physician Executives. ...The Tri-County Voluntary Action Center honored the Ingham County Medical Society for its "Doctor Care" program giving free medical assistance to the disadvantaged. This program was inaugurated by past-president, **Paul C. Linnell, MD**. ...Thomas Harris, MD, has been elected president of the Jackson County Medical Society. ...**William Zimmerman, MD**, Grand Rapids, is on the Board of Directors of the Flying Physicians Association. The group's membership is made up of physician pilots. ☐

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MSMS MEETINGS

July

16-19, MSMS Board of Directors Midsummer Meeting, Deer Lake, Boyne Mountain, contact: William Madigan (517)337-1351.

September

23, MSMS Board of Directors Meeting, MSMS headquarters, East Lansing, contact: William Madigan (517)337-1351.

October

20, County Medical Society Executives Meeting, MSMS headquarters, East Lansing, contact: Kevin Kelly, MSMS headquarters (517)337-1351.

21, 1987 Public Affairs Leadership Conference, Clarion Hotel and Conference Center, Lansing, contact: Sherry Wellman, MSMS headquarters (517)337-1351.

November

18, MSMS Board of Directors Meeting, MSMS headquarters, contact: William Madigan (517) 337-1351.

AMA MEETINGS

July

8-11, AMA National Conference on the Impaired Health Professional. "Impaired Health Professionals: Educating Ourselves. . . Educating Others," Drake Hotel, Chicago, contact: Janice J. Robertson, AMA Department of Substance Abuse, 535 N. Dearborn Street, Chicago, IL 60610 (321)645-5083.

MICHIGAN SPECIALTY SOCIETY MEETINGS

July

10, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

10-11, Michigan Society of Thoracic Surgeons Annual Meeting, Grand Traverse Resort Village, Traverse City, contact: Rodman E. Taber, MD, secretary (313) 567-1640.

10-12, Michigan Dermatological Society, Grand Traverse Resort Village, Traverse City, contact: Debbie Samalis, executive secretary (313)554-1891.

August

15-16, Michigan Academy of Family Physicians Congress of Delegates, Grand Traverse Resort Village, Traverse City, contact: Janice Klos, chief executive officer (517)482-7410.

17-19, Michigan Academy of Family Physicians Annual Meeting, Grand Traverse Resort Village, Traverse City, contact: Janice Klos, chief executive officer (517)482-7410.

18-21, Michigan Health Officers Association, Annual General Membership Meeting, Grand Traverse Resort Village, Traverse City, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

19-20, Michigan Society of Thoracic Surgeons Meeting, Grand Hotel, Mackinac Island, contact: Rodman E. Taber, MD, secretary (313) 567-1640.

22-24, 28th Congress of the Michigan Association of the Professions: The Homecoming, Grand Hotel, Mackinac Island. Registration information will be sent to members during the early summer.

September

4, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

October

2, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

November

6, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

December

4, Michigan Health Officers Association, Board of Directors Meeting, Michigan Department of Public Health, Room 1D, contact: David J. Lieberman, MD, president, Michigan Health Officers Association, 650 Stewart Road, Monroe 48161 (313)243-7144.

NATIONAL SPECIALTY SOCIETIES

August

3-7, American College of Physicians, 35th Annual Internal Medicine Update and Board Review, University of Southern California School of Medicine, Los Angeles, CA, contact: American College of Physicians, 800-523-1546.

6-8, American College of Obstetricians and Gynecologists, Update in Obstetrics, Four Seasons Hotel, Vancouver, BC, Canada, contact: American College of Obstetricians and Gynecologists, (202)638-5577.

13-15, American College of Obstetricians and Gynecologists, Advanced Ultrasound, Silverado NAPA, CA, contact: American College of Obstetricians and Gynecologists, (202)638-5577.

14-17, American Academy of Family Physicians Annual Meeting, San Francisco, contact: Robert Graham, MD, 1740 W. 92nd Street, Kansas City, MO 64114.

17-21, American College of Physicians, 7th Annual Hilton Head Conference: Update on Critical Care Medicine, Hyatt on Hilton Head Island, Hilton Head, SC, contact: American College of Physicians, 800-523-1546.

17-18, American Academy of Facial, Plastic and Reconstructive Surgery Annual Meeting, Chicago, contact: Lee VanBremen, PhD, 1101 Vermont Avenue, NW, Suite 404, Washington, DC 20005 (202)842-4500.

19-23, American Academy of Otolaryngology, Head and Neck Surgery, Chicago, contact: Jerome C. Goldstein, MD, 1101 Vermont Avenue, NW, Suite 303, Washington, DC 20005 (202)289-4607.

20-22, American College of Obstetricians and Gynecologists, Controversies in Obstetrics and Gynecology, Sonesta Hotel, Portland, ME, contact: American College of Obstetricians and Gynecologists, (202)638-5577.

26-29, American College of Physicians, Treatment of Rheumatic Diseases for the Practicing Intern, University of Ottawa, Ottawa, Ontario, Canada, contact: American College of Physicians 800-523-1546.

28-9/1, American Psychological Association, APA 95th Annual Convention, New York Hilton, New York, NY, contact: American Psychological Association (202) 955-7705.

September

2-5, American Academy of Pediatrics, Current Concepts in Pediatrics, Sheraton Boston and Towers, Boston, MA, contact: American Academy of Pediatrics 800-433-9016.

11-13, College of American Pathologists, Capitalizing on Education Anatomic Pathology, Quality Assurance, Applications of Microcomputers in the Lab, Hyatt Regency, Cambridge, MA, contact College of American Pathologists (312)966-5700.

13-17, American Academy of Orthopaedic Surgeons, AAOS Summe Institute, Boston, MA, contact American Academy of Orthopaedi Surgeons, (312)823-7186.

14-17, American Academy o Family Physicians, Annual Scientifi Assembly, Moscone Conventio Center, San Francisco, CA, contact American Academy of Family Physicians, 800-821-2512.

17-19, American Academy o Otolaryngic Allergy, Annual Meeting, Chicago Marriott, Chicago. contact: American Academy o Otolarygic Allergy, (202)682-0456.

OTHER MEETINGS

July

29-8/1, AAMSE 6th Annual Conference, New Orleans, contact American Association of Medica Society Executives, 1 East Eri Street, Chicago, IL 60611 (312)280-7265.

September

24-26, One Who Stays: A Symposium on the Humanities, Medicine, and AIDS, contact: Lind Garcia-Shelton, PhD, Associate Professor and Director of Behaviora Science, St. Joseph Hospital—Michigan State University Famil Practice Residency, 302 Kensington Flint 48502 (313)762-8000. □

CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category 1 credit toward meeting the requirements of Michigan law. Sponsors of Category 1 programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS headquarters, (517) 337-1351.

July

5-8, Internal Medicine Update. Location: Grand Hotel, Mackinac Island. **Sponsor:** The University of Michigan Medical School, Department of Internal Medicine, Ann Arbor. **Contact:** Gayle Fox, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Box 0201, Ann Arbor 48109-0201 (313)763-1400. // b**Approved for:** 11.25 hours Category I Credit.

12-15, Fourteenth Michigan Emergency Medicine Assembly. **Location:** Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** Michigan Chapter of the American College of Emergency Physicians and Michigan State University College of Osteopathic Medicine. **Contact:** Kathy Hopkins, Michigan ACEP, 1305 Abbott, Suite 104, East Lansing, 48823 (517)332-6500. **Approved for:** 28 hours Category I Credit.

13-17, American Association of Radiological Physicists. **Location:** Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0201. **Sponsor:** University of Michigan Medical School . **Contact:** Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 12 hours Category 1 Credit.

17-18, Practical Approach to the Diagnosis and Management of Cardiopulmonary Diseases. Location: Grand Traverse Resort Village, Traverse City. **Sponsor:** Michigan State University College of Osteopathic Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 E. Fee Hall, East Lansing, MI 48824-1316. **Approved for:** 10 hours Category 1 Credit.

30-31, Coller Penberthy Thirlby Medical Conference. Location: Grand Traverse Resort, Traverse City. **Sponsor:** Munson Medical Center. Traverse City. **Contact:** Elaine Gaines, Medical Education Secretary, Munson Medical Center, 1105 Sixth Street, Traverse City 49684-2386 (616)922-9546. **Approved for:** 9 hours Category I Credit.

31-8/2, Tutorial on Level II Myofascial Release Technique. **Location:** The Homestead Resort, Glen Arbor. **Sponsor:** Michigan State University College of Osteopathic Medicine and College of Human Medicine. **Contact:** Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 East Fee Hall, East Lansing, MI 48824-1316. **Approved for:** 24 hours Category I Credit.

August

7-9, Diabetes and Endocrinology Update. Location: Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** University of Michigan Medical School. **Contact:** Betty Phillips, Office of Continuing Medical Education, Towsley Center, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 7.3 hours Category I Credit.

9-14, Symposium on Breast Disease: Diagnostic Imaging and Current Management. **Location:** Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** University of Michigan Medical School, Department of Radiology and Office of Continuing Medical Education. **Contact:** Gayle Fox, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 20.3 hours Category 1 Credit.

10-14, Mammography Conference. Location: Grand Traverse Resort Village, Grand Traverse Village. **Sponsor:** University of Michigan Medical School. **Contact:** Jean Holther, Office of Continuing Medical Education, Towsley Center, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 15 hours Category I Credit.

14-17, Thirteenth Annual Mackinac Island Course: Advances in the Management of Infectious Diseases. Location: Grand Hotel, Mackinac Island. **Sponsor:** University of Michigan Medical School, Division of Infectious Diseases and Department of Internal Medicine. **Contact:** Betty Phillips, Office of Continuing Medical Education, Towsley Center, The University of Michigan Medical School, Box 0201, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 10 hours Category 1 Credit.

31-9/3, Advanced Cardiac Life Support Provider Course. (August 31 and September 2 Recertification Course—8 Category I Credits—4 for BCLS and 4 for ACLS). Location: Borgess Medical Center, Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Center, Staff and Patient Education Department. **Contact:** Claire A. Zieman, Staff and Patient Education, Borgess Medical Center, 1521 Gull Road, Kalamazoo 49001 (616)383-8320. **Approved for:** 25 Category 1 Credits (4 for BCLS and 21 for ACLS).

September

10-12, Advanced Cardiac Life Support (Provider & Recertification) Course. Location: Gilmore Center of Health Education Bronson Methodist Hospital, Kalamazoo. **Sponsor:** Bronson Life Support Services and Southwestern Michigan Area Health Education Center. **Contact:** Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. **Approved for:** Category 1 Credit: 20 credits for ACLS and 4 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

10-12, Head and Neck Oncology Research. Location: Towsley Center for Continuing Medical Education, The Universtiy of Michigan Medical School, Ann Arbor 48109-0201. **Sponsor:** University of Michigan Medical School. **Contact:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor 48109-0201 (313)763-1400. **Approved for:** 24 hours Category 1 Credit.

12-16, Tutorial On Level I Muscle Energy Technique. Location: Kellogg Center for Continuing Education, Michigan State University, East Lansing 48824. **Sponsor:** Michigan State University College of Osteopathic Medicine. **Contact:** Sandy Kilborn, Director of Continuing Medical Education, Michigan State University, College of Osteopathic Medicine, A306 East Fee Hall, East Lansing 48824-1316 (517)353-9714. **Approved for:** 40 hours Category 1 Credit.

16, Current Issues in Chemical Dependency. Location: Saint John Hospital, 22101 Moross Road, Detroit. Sponsor: The Continuing Medical Education Committee of Saint John Hospital. Contact: Mary Ann Richards, Program Coordinator, Continuing Medical Education, Saint John Hospital, Detroit 48236 (313)343-4000. Approved for: 7 hours Category I Credit.

17-19, 10th Annual Seminar in Diagnostic Ultrasound. Loction: The Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0010. Sponsor: The University of Michigan Medical School, Department of Radiology. Contact: Jolene Glaspie, Towsley Center for Continuing Medical Education, The University of Michigan Medical School, Ann Arbor 48109-0010 (313)763-1400. Approved for: 14.1 hours Category I Credit.

18-20, Tutorial on Level I Myofascial Release Technique. Location: Kellogg Center for Continuing Education, Michigan State University, East Lansing. Sponsor: Michigan State University College of Osteopathic Medicine and College of Human Medicine. Contact: Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 East Fee Hall, East Lansing 48824-1316 (517)353-9714. //Approved for: 24 hours Category I Credit.

19, Emergency Medicine Oral Boards Preparation Workshop. Location: St. Mary's Hospital, Saginaw. Sponsor: St. Mary's Hospital and Michigan State University College of Osteopathic Medicine. Contact: Michigan ACEP, 1305 Abbott Road, Suite 104, East Lansing 48823. Approved for: 5 hours Category I Credit.

19, New Directions in Psychiatry: The Mind, The Body, The Environment. Location: Sheraton Fashion Square, Saginaw. Sponsor: Bay Medical Education. Contact: Dodie Roth, Bay Medical Education, 615 Ninth Stret, Bay City 48708 (517)892-1501. Approved for: 7 hours Category I Credit.

24-26, The Grand Rapids 18th Annual International Symposium on Implant Surgery for the Hand, Upper Extremity, and Foot. Location: Blodgett Memorial Medical Center and Amway Grand Plaza Hotel, Grand Rapids. Sponsor: Michigan State University College of Human Medicine, The International Federation of Societies for Surgery of the Hand, The Dissemination of Knowledge Foundation, and Blodgett Memorial Medical Center. Contact: Alfred B. Swanson, MD, Blodgett Professional Building, 1900 Wealthy, S.E., Suite 290, Grand Rapids 49506 (616) 774-0440. Approved for: 18 hours Category I Credit.

26-30, Tutorial on Level II Manual Medicine Techniques (Above Diaphragm). Location: Kellogg Center for Continuing Education, Michigan State University, East Lansing. Sponsor: Michigan State University College of Osteopathic Medicine and College of Human Medicine. Contact: Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 E. Fee Hall, East Lansing 48824-1316 (517)353-9714. Approved for: 40 hours Category I Credit.

October

9, 17th Annual Cardiology Symposium: Rationale for Emergency Intervention in Acute Myocardial Infarction. Location: Kalamazoo Center Hilton Inn. Sponsor: Southwestern Michigan Area Health Education Center, Michigan Academy of Family Physicians, Borgess Cardiovascular Services. Contact: Sharon Nocera, Borgess Cardiovascular Services, 1521 Gull Road, Kalamazoo 49001 (616)383-5930. Approved for: 6.25 hours Category I Credit.

9-11, 38th Annual Meeting, Michigan Chapter American Academy of Pediatrics. Location: Grand Traverse Resort Complex, Traverse City. Sponsor: Michigan Chapter American Academy of Pediatrics. Contact: John H. Romanik, MD, Co-Chairman, 39500 West Ten Mile Road, Novi 48050 (313) 478-8040. Approved for: 7 hours Category I Credit.

12-14, Industrial Problems of the Upper Extremity in the US and Canada. Location: Ann Arbor. Sponsor: American Society for Surgery of the Hand. Contact: Kathie File, American Society for Surgery of the Hand, 3025 South Parker Road, Suite 65, Aurora, Colorado 80014 (313)755-4588. Approved for: 18 hours Category I Credit.

15-16, Practical Neonatal Neurology. Location: The Towsley Center, The University of Michigan, Ann Arbor. Sponsor: The Office of Continuing Medical Education of the Univesity of Michigan Medical School. Contact: Betty Phillips, Office of Continuing Medical Education, Towsley Center, Box 0201, Ann Arbor 48109-0201, (313)763-1400. Approved for: 12.1 hours Category I Credit.

30-11/3, Tutorial on Level II Craniosacral Techniques. Location: Kellogg Center for Continuing Education, Michigan State University, East Lansing. Sponsor: Michigan State University College of Osteopathic Medicine and College of Human Medicine. Contact: Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 E. Fee Hall, East Lansing 48824-1316 (517)353-9714. Approved for: 40 hours Category I Credit.

21, Thyroid Update. Location: Saint John Hospital, 22101 Moross Road, Detroit. Sponsor: The Continuing Medical Education Committee of Saint John Hospital. Contact: Mary Ann Richards, Program Coordinator, Continuing Medical Education, Saint John Hospital, 22101 Moross Road, Detroit 28236 (313)343-4000. Approved for: 7 hours Category I Credit.

November

5-7, Advanced Cardiac Life Support (Provider & Recertification) Course. Location: Gilmore Center of Health Education Bronson Methodist Hospital, Kalamazoo. Sponsor: Bronson Life Support Services and Southwestern Michigan Area Health Education Center. Contact: Cyndi Kochevar-Bouma, Bronson Life Support Services, Bronson Methodist Hospital, 252 E. Lovell Street, Kalamazoo 49007 (616)383-7576. Approved for: Category I Credit: 20 credits for ACLS and 6 credits for BCLS; Recertification—4 credits for ACLS and 5 for BCLS.

10-12, 1987 MSMS Annual Scientific Meeting. Location: Hyatt Regency Dearborn. Sponsor: MSMS and cooperating specialty societies, sections, medical school departments and hospitals. Contact: Sherry L. Fent, Chief, Physician Education, MSMS, P.O. Box 950, East Lansing, 48826-0950 (517)337-1351. Approved for: a maximum of 18 Category I Credit hours for the three day conference.

20-22, Tutorial on Manual Medicine Techniques Applied to the Extremities. Sponsor: Michigan State University College of Osteopathic Medicine and College of Human Medicine. Contact: Sandy Kilbourn, Director of Continuing Medical Education, Michigan State University, A306 E. Fee Hall, East Lansing 48824-1316 (517)353-9714. Approved for: 24 hours Category I Credit.

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Continued on next page

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Impaired MD program seeks hospital participation

By Carl A. Gagliardi, MD

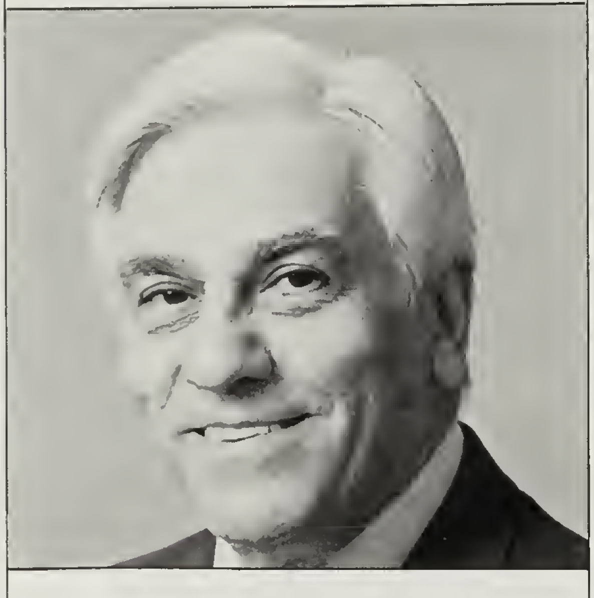
At his request, Doctor Gagliardi's article is excerpted with permission from *Michigan Hospitals*, April 1987.

In the early 1970s, it became obvious to members of the Michigan State Medical Society that we could no longer ignore our chemically dependent colleagues, allowing them to sink or swim on their own. Surely we would not allow a diabetic, filled with denial, to degenerate while we sat idly by, pretending not to know.

Today we have a structure that reaches throughout the state, extending from the MSMS headquarters out to county medical societies, specialty societies, and many hospital medical staffs. General policies are set at the state level by the Steering Committee to Assist Impaired Physicians, and these policies are in turn subject to review and approval by the MSMS Board of Directors.

Local committees throughout the state play a vital role in a the day to day activities of the program. One of the primary objectives of these committees is to heighten physicians' awareness of the program. Only then can we hope to get maximum involvement and participation by physicians in the all important case-finding process.

Confidentiality is of the utmost importance, or referrals would become nonexistent and confidence in the program would evaporate. Not only must the identity of the impaired physicians be kept confidential, but the identity of the person making the referral must be protected as well.



In 1983 the Michigan Association of Osteopathic Physicians and Surgeons requested assistance from us in instituting a similar program for their members. As a direct result of these discussions, our program was expanded to include both MSMS and MAOPS.

Expansion plans underway

The program in Michigan is expanding in two important directions. We hired a full-time professional director to coordinate all the activities of our program, Gerald VanderVoord, MD, East Lansing family physician.

Second, but equally important, we will seek a closer working relationship with the Michigan Board of Medicine. The AMA has proposed model legislation for such a partnership, and the MSMS legal advisor has adapted this to address our specific needs. We hope to obtain such enabling legislation soon so that the society-sponsored program will have the necessary tools to offer a comprehensive diversionary program to rehabilitate physicians affected with problems of substance abuse and/or mental illness. The ultimate goal is re-entry into normal professional and personal activities.

Although the primary purpose of this program is protection of the public, our philosophy is that unnecessary publicity does not serve either the public or the physician involved. Therefore, it is absolutely essential that the committee be allowed to maintain confidential records of its deliberations and proceedings and that such records as well as the individual members of the committee be protected from subpoena. Any impaired physician who refuses to undergo treatment or who is not substantially improved by treatment will be reported to the Board of Medicine for disciplinary action.

The program could be expanded to include many other health professionals: nurses, pharmacists, and hospital administrators, to name a few. Our ultimate goal is for earlier detection and treatment rather than late detection, discipline, and lost lives. There are few activities that offer so much potential for so little effort and cost. ☐

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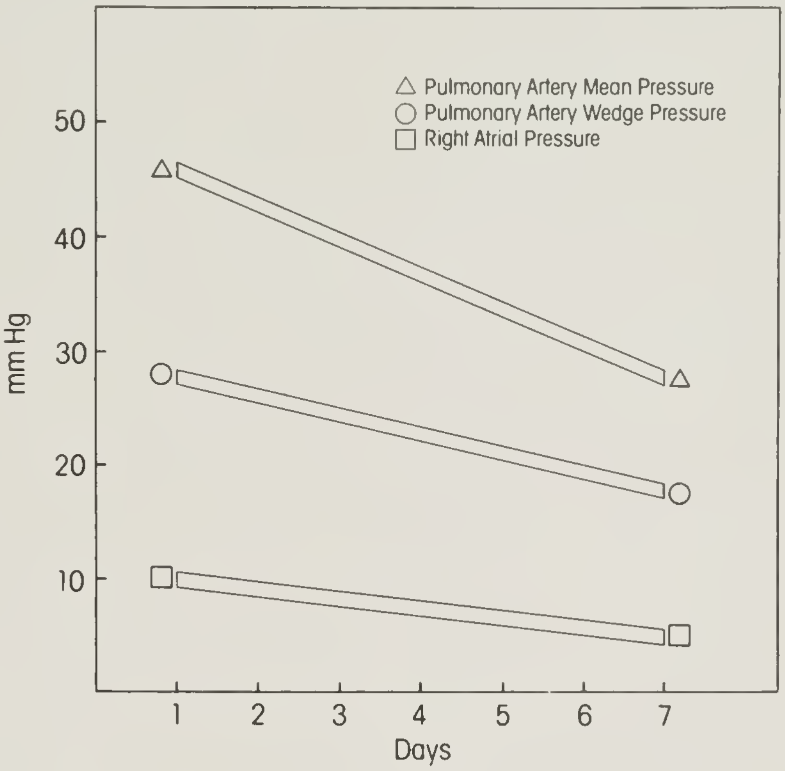

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References: 1. Olesen KH, *et al* *Postgrad Med J 51*(Suppl 6) 54-63, 1975 **2.** Handler B, Dhingra RC, Rosen KM: *J Clin Pharmacol 21* 706-711, Nov-Dec 1981 **3.** Brater DC, *et al* *Clin Pharmacol Ther 34* 207-213, Aug 1983 **4**. Brater DC, Fox WR, Chennavasin P *J Clin Pharmacol 21* 599-603, Nov-Dec 1981 **5.** Davies DL, *et al* *Clin Pharmacol Ther 15* 141-155, Feb 1974

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Prevention of hypokalemia requires particular attention in patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis and ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, certain diarrheal states, or other states where hypokalemia is thought to represent particular added risks to the patients
In patients with hepatic cirrhosis and ascites, sudden alterations of electrolyte balance may precipitate hepatic encephalopathy and coma Treatment in such patients is best initiated in the hospital with small doses and careful monitoring of the patient's clinical status and electrolyte balance Supplemental potassium and/or spironolactone may prevent hypokalemia and metabolic alkalosis in these patients
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Especially in presence of impaired renal function, use of parenterally administered Bumex should be avoided in patients to whom aminoglycoside antibiotics are also being given, except in life-threatening conditions
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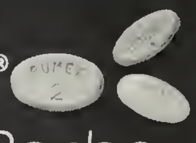
Reduce fluid volume and improve hemodynamics in CHF
Edema due to congestive heart failure often demands highly effective diuresis to reduce the fluid load on the failing heart. Bumex® (bumetanide/Roche) is the next generation in loop diuretic therapy for three powerful reasons. It moves out an unsurpassed volume of fluid and sodium, resulting in significant reductions in edema and right atrial and pulmonary artery wedge pressures.[1,2] It's almost completely absorbed through the GI tract, so it's easy to titrate.[3] And Bumex completes high-volume diuresis fast—within four hours at usual doses.[4,5] Your patients spend less time in diuresis, more time in normal activities.

Bumex has a good safety profile; however, as with all loop diuretics, Bumex, if given in excessive amounts, can lead to profound diuresis with water and electrolyte depletion, including hypokalemia. Serum electrolytes should be monitored periodically, especially in patients on low salt diets or those treated for prolonged periods or on high doses.

Bumex®
bumetanide/Roche



0.5-mg, 1-mg and 2-mg scored tablets, 2-ml ampuls (0.25 mg/ml) and 2-ml, 4-ml and 10-ml vials (0.25 mg/ml)

First line loop diuretic therapy

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